Health Care Financing Administration

Forum

November/December 1977

Home Care for the Elderly Costs Less.

How Canada Holds Down Drug Costs.

Hearings on National Health Insurance.

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Forum

Volume 1, Number 2 • Nov. / Dec. 1977

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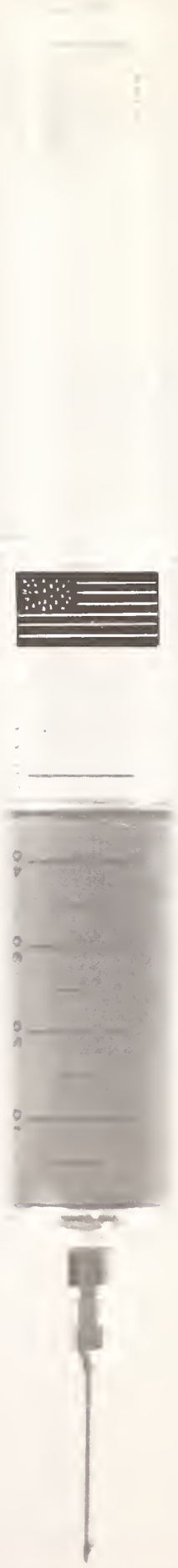
Cover: Burkey Belser. Illustrations: Len Epstein, page 32; John Metelsky, page 15.

The Forum is published by the Health Care Financing Administration of HEW. It is issued six times a year by the Office of Public Affairs. Annual subscriptions are $6.75 (domestic) and $8.50 (foreign) and are paid to the Superintendent of Documents, Washington, D.C. 20402. Single copy price is $1.20, domestic; $1.50, foreign. Address manuscripts and article ideas to the Editor, Rm. 5327, MES Building, HCFA/HEW, Washington, D.C. 20201. Telephone 202-245-2196. Publication funds were approved by the Office of Management and Budget on February 25, 1972, amended December 4, 1973. Controlled circulation permit paid at Main Post Office, Washington, D.C.



How Canada Holds Down Dr

by Virginia Douglas, Assistant Editor

While prescription prices in the U.S. have generally risen in the past few years, some of the same drugs in Canada have dropped significantly in price due to government programs that promote competition among drug manufacturers.

The chief factor is a law under which the Canadian government can require a patent holder to allow other firms to manufacture or import a drug for sale in Canada. Other measures to increase competition are loans and grants to manufacturers, publishing comparative price information and passage of laws enabling pharmacists to fill prescriptions from among all available brands.

And, to assure consumers, physicians and pharmacists that drug quality will not suffer when lower priced drugs are used, both the national and provincial governments inspect and evaluate drug firms' manufacturing processes and products.

A report* on the Canadian experience from 1970 to 1974 by two HEW researchers compares data on 16 frequently prescribed drugs for Canada and the United States. The average price of the drugs fell 39.1 percent, while in the U.S. the price of the drugs fell only two percent. The study suggests ways the U.S. can control the cost of prescription drugs, while allowing manufacturers a fair return and maintaining quality.

Compulsory patent licensing

Since 1923, the Canadian government has been able to grant compulsory licenses—that is, license firms other than the holder of a drug patent to manufacture and sell the drug in Canada. (Of course, many patent holders voluntarily license other firms also to sell products on which they hold patents.) In 1969, the government's licensing power was broadened to allow holders of compulsory licenses to sell imported drugs.

During the next six years, 109 compulsory license applications were approved for a total of 42 drugs.

The question of the amount of royalties the licensee should pay the patent holder proved a thorny one. It was decided by the Commissioner of Patents. An example of the complexities involved in determining royalties was diazepam, patented by Roche. Sold in the U.S. under the name Valium, it is the most frequently prescribed U.S. drug. The Canadian patent holder, Roche Canada, and the first license applicant, Frank W. Horner, could not agree on the level of royalty payments. Until the 1969 amendment to the patent law, royalties were based on the cost of the bulk chemical. But for diazepam, Roche and Horner disagreed on this base cost.

Horner, quite naturally, proposed a modest cost—$87 per kilogram of the drug in raw form, which it planned to obtain from an Italian manufacturer. Roche, on the other hand, claimed the base cost on which it should receive royalties should be much higher: $2,978 per kilogram.

What accounted for the difference? Roche felt that fixed overhead costs should be included in the base price of the drug—costs it would continue to incur even if another firm bought diazepam elsewhere and marketed it. Among the costs claimed by Roche were:

- Research, $1,108 per kilogram.
- Return on capital employed in research and provision of medical information, $546 per kilogram.
- Obtaining and maintaining medical acceptance of ethical drugs (advertising, literature, samples, detailing, maintaining a medical department and market research), $1,323.76 per kilogram.

However, at a government hearing, it became clear that Roche could make diazepam in raw form at the same $87 per kilogram Horner planned to pay the Italian manufacturer.

Faced with this dilemma, the Commissioner of Patents accepted neither argument. Instead, he granted

*Fulda, Thomas R. and Paul F. Dickens, III, *Controlling the Cost of Prescription Drugs: The Canadian Experience.*

Costs.

Roche a royalty of four percent of Horner's net (wholesale) selling price of diazepam. In his opinion, the commissioner noted that that figure was easily ascertained, while such amounts as the net selling price of raw material were difficult to establish and might be the source of argument and delay between applicant and patentee.

Another case decided by the commissioner involved two foreign holders of Canadian patents: A Swiss manufacturer, Sandoz, and a French firm, Societe des Usines Chimiques Rhone-Poulenc. The former manufactured the final form of thioridazine, while the latter was responsible for processing the raw material for making it. In granting four compulsory licenses to Jules R. Gilbert, Ltd., to import, make and sell the drug, the commissioner split the four percent royalty, giving each patentee two percent.

The four percent figure was also used in a more complicated case—that of ampicillin, for which 30 patents were held by four different firms. In granting compulsory licenses to 10 applicants, the Commissioner of Patents allowed each of the four patentees a one percent royalty on the sale of ampicillin to the pharmacist.

Strengthening pharmaceutical firms

Compulsory licensing was only one step taken by Canada to assure competition in the prescription drug field. Other measures were employed to develop more pharmaceutical firms of sufficient financial strength to stimulate competitive prices.

In 1968, the Canadian Department of Trade began providing loans to Canadian drug firms to improve their capabilities in marketing, manufacturing or research and development. To receive these loans, firms must show that they cannot obtain the needed money elsewhere and that they have or can acquire the skills and capabilities needed to carry out an approved plan for manufacturing pharmaceuticals.

Also, firms undertaking research and development relating to drugs may obtain government support. A firm can receive either a tax-free grant or a tax credit equal to 25 percent of its capital expenditures for a given year, plus 25 percent of its increase in such expenditures over the average of expenditures for the five preceding years. Firms obtaining grants or credits must market the results of such research in Canada.

To encourage the development of new technology, the government will pay up to half the cost of industrial design, pilot plants, test equipment, production tooling and similar expenses.

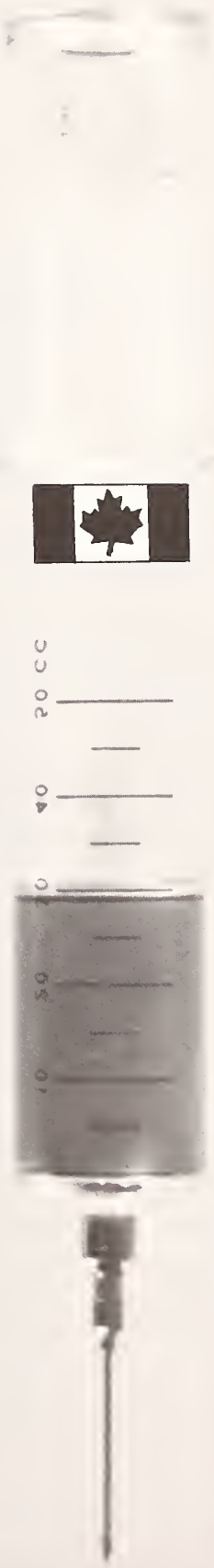
Drug information and selection

The government also wanted to encourage Canadian physicians and pharmacists to select the lower-priced product from among drugs that were chemically identical and of adequate quality. Thus, more information on drug price and quality has been made available and, in some situations lower priced drugs must be selected.

Ontario, which constitutes some 35 per cent of the Canadian drug market, has developed several methods to save its citizens money on prescription drugs. Over half of the pharmacies in the province take part voluntarily in the Parcost program, begun in 1969, which promotes both high quality and lower prices for drugs.

Under this program, a participating pharmacist agrees to limit the price he charges a customer for a prescription to the maximum cost listed for such drugs in the Parcost *Comparative Drug Index* and to base his dispensing fee on the professional fee method. (In 1975, the dispensing fee could not exceed $2.60 per prescription.)

In 1972, Ontario amended its Pharmacy Act to provide that a lower cost drug could be substituted for one prescribed as long as both products were listed as interchangeable in the *Index* and the physician had not specified that substitution could not be made.



Comparison of U.S. and Canadian Drug Prices

	Average price of all manufacturers (Estimated)				Percentage change	
	1970		1974		1970–1974	
	Canada*	U.S.	Canada*	U.S.	Canada*	U.S.
Amitriptyline, 25 mg	4.16¢	7.1¢	4.24¢	7.2¢	+ 1.9%	+ 1.4%
Ampicillin, 250 mg	16.83	17.3	6.06	7.5	−64.0	−56.6
Chlordiazepoxide, 10 mg	4.46	5.9	2.63	6.0	−41.0	+ 1.7
Chlorothiazide, 500 mg	3.37	4.9	3.74	4.9	+11.0	0
Chlorpromazine, 50 mg	4.36	4.8	5.25	4.3	+20.4	−10.4
Chlorthalidone, 100 mg	4.75	6.9	6.06	7.7	+27.6	+11.6
Diazepam, 5 mg	5.05	7.1	2.73	7.3	−45.9	+ 2.8
Erythromycin Estolate, 250 mg	19.90	21.8	9.09	19.4	−54.3	−11.0
Glutethimide, 500 mg	4.26	4.4	4.75	5.6	+11.5	+27.3
Imipramine, 25 mg	6.34	7.1	4.85	9.4	−23.5	+32.4
Methylphenidate, 10 mg	4.16	5.1	4.55	6.0	+ 9.4	+17.7
Metronidazole, 250 mg	10.89	13.7	6.67	14.3	−38.8	+ 4.4
Oxtetracycline, 250 mg	19.70	17.6	18.59	17.5	− 5.6	− 0.6
Thioridazine, 25 mg	4.65	7.6	4.55	8.0	− 2.2	+ 5.3
Triamcinolone, 4 mg	21.78	15.7	18.89	16.2	−13.3	+ 3.2
Trifluoperazine, 5 mg	8.81	9.6	7.58	9.7	−14.0	+ 1.0
Average price per dose	5.74	7.4	3.46	7.3	−39.72	− 1.4

* Canadian prices adjusted to eliminate differences in exchange rates between the U.S. and Canada.

Another step to encourage lower drug costs was taken in 1974 when Ontario began an insurance program that provided prescription drugs for welfare recipients and needy people over 65. The province required that the lowest priced of equivalent drugs listed in the *Index* be dispensed to fill a prescription, with the pharmacist allowed a $2.10 dispensing fee for each prescription.

Other provinces have enacted or proposed drug laws that encourage a pharmacist to save the customer money by filling a prescription for an interchangeable drug with the cheapest drugs. Previously, so-called antisubstitution laws prevented this. Such laws were also common in the United States in the early 1970's, although many state legislatures were considering changes.*

In spite of legislative efforts to reduce drug costs to consumers, the 1973 amendment to the Pharmacy Act contained a loophole. The law applied only to prescriptions written for brand name drugs. Nothing prohibited a pharmacist receiving a prescription for a generic drug from filling it with any brand on hand—even one higher in price. Also, unless the pharmacy was operating under a Parcost contract, the pharmacist could not be held to the $2.60 dispensing fee. This was remedied by the Health Disciplines Act of 1975.

Another province, Manitoba, mandates dispensing the lowest priced interchangeable drug that is listed in the Manitoba drug index, unless the physician directs otherwise. The province also sets a dispensing fee limit.

Assurance of quality

"I am fully aware of the fact that many physicians and pharmacists are reluctant to prescribe and dispense generic or other lower cost drugs, unless they can be assured that low-cost drugs are of acceptable quality," said John Munro, Canadian minister of National Health and Welfare. "Any program aimed at reducing drug costs must, therefore, recognize the need to provide objective information on drug quality to the professions of medicine and pharmacy."

Shortly after this statement in 1971, Canada's Drug Quality Assessment Program was announced. Participation was voluntary. Annual plant evaluations were performed at the request of the manufacturer. Government inspectors visited drug manufacturing plants and evaluated both facilities and processes in detail. Such aspects as quality control procedures, storage, distribution and record-keeping were checked.

The program concentrated on the most frequently prescribed drugs—single products manufactured by more than one firm and having a sales volume in excess of $100,000 per year. Drugs were tested for identity, potency, content uniformity, weight variation and disintegration time. To estimate the clinical equivalency, bioavailability studies were performed. Panels of medical advisors determined acceptable advertising claims for the drugs.

With more and more provinces setting up health insurance plans that provide drug benefits, the Drug Quality Assessment Program now has begun to help the provincial governments identify effective drugs of acceptable quality.

Effect of competition

To learn whether compulsory licensing, assistance to manufacturers, comparative price information and product selection programs affected Canadian drug prices, the HEW researchers examined pricing and sales data for 16 drugs heavily prescribed in both Canada and the United States. (See accompanying chart.) For all 16, the Canadian drug patent holders faced competition from at least one compulsory licensee during the period studied, 1970-1974.

Did increased competition lead to lower prices? The average price per dose fell 39.1 percent for the 16 drugs between 1970 and 1974. Prices declined for 10 of the 16 drugs for which compulsory licenses were issued. For those 10 drugs, the range in decline was wide—from 4.3 to 64.7 percent. It is clear that, in at least eight of the 10 cases of price decline, the licensees' sales were responsible for the decline.

On average, the licensees' prices for drugs dropped much lower than did the patent holders' prices: 67.5 percent versus 22.2 percent over five years. This suggests that licensees may have discovered such price cuts were the only way they could successfully compete in the market.

For five of the 16 drugs for which compulsory licenses were issued, prices increased.* Generally, this occurred where licensees had little or no share of the market and where the size of the market was declining.

The researchers noted that, in nearly all cases where the licensee market for a drug increased, the total market increased. Perhaps licensees were attracted to drugs with growing potential. It is also possible that the drop in prices that accompanied increased competition caused more consumers to buy those drugs.

By comparison with Canada, U.S. prices for this group of 16 drugs over the same time period did not decline significantly. Statistical tests of the data verified this conclusion. While the average Canadian price declined by 39 percent, the average U.S. price declined by less than two percent. In fact, the price in the U.S., which has no programs similar to Canada's, increased for 11 of the 16 drugs. This contrast supports the conclusion that, by increasing competition, the Canadian programs are substantially responsible for the different pricing pattern observed.

"Canada's success in using a multi-faceted approach to lower prices of a group of heavily prescribed drugs demonstrates the importance of competition in the drug industry," says Vincent Gardner, chief of the Office of Pharmaceutical Reimbursement of the Medicaid Bureau. "The numerous price increases in prescription drugs in the United States in recent years contrast sharply with the Canadian experience and indicate that we should give the Canadian programs serious study when formulating cost containment policies for the United States."

However, he pointed out that the study focuses only upon the Canadian programs' impact on drug prices, and not on how they may have affected the long-term financial stability of the manufacturers and their ability to maintain appropriate research programs. ■

*As of 1977, 32 states have adopted some form of legislation permitting drug substitution.

*For one drug, the prices in 1970 and 1974 were the same.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Hospital Provides Home Care for Elderly at One-Half Nursing Home Cost.

by Philip Brickner, M.D. and Linda Keen Scharer

Aged, homebound, isolated people survive with difficulty. Because they are physically disabled, they lack access to standard sources of health care. Because they are alone, afraid, and uncertain, they are unable to demand help. They are among the medically unreached. Unless programs can be designed to provide assistance, their fate is often unattended death at home or forced transfer to a long-term care institution.

The problem

Social policy in the United States has supported long-term institutional care rather than the maintenance of elderly people in their own homes. For example, home health payments for the elderly are projected at only $356 million for 1977. This compares to $5.6 billion which State and Federal governments are expected to spend over the same period to maintain people in nursing homes.

As our population ages, the financial cost of institutional care will grow, unless we devise alternatives. In 1900, one in every 25 Americans was 65 or over. In 1975 the proportion was one in 10. Projections of the number of elderly people in the United States by the year 2,000 depend on many variables, but a reasonable estimate is 30.6 million. This is one in every eight individuals. Nearly two million will be homebound; this estimate is based on the current percentage of the homebound within the elderly population.

Dr. Philip Brickner is director of the Department of Community Medicine at St. Vincent's Hospital and Medical Center. Linda Keen Scharer holds a master's degree in urban planning and is assistant to the director of the Department of Community Medicine. The financial analysis of the program was performed by John Boehringer. Reprints of this article may be obtained from Dr. Brickner, 153 West 11th Street, NY 10011.

Rationale for a solution

Programs which bring services to elderly people who are homebound are essential if transfer to an institution is to be avoided. A successful program helps elderly people to remain in their own homes, where they often wish desperately to stay; and it meets the needs of society at large, because home health care can be substantially less expensive than nursing home care.

The financial costs of nursing home care are significant. In New York City, for instance, the least expensive nursing home, supported entirely by Medicaid, costs the government $800 per month. The cost of the average nursing home bed is substantially higher, in the range of $1,200 to $1,600 a month. Measurements of home health care programs show that, for semi-ambulatory people, the total costs of home health maintenance, including home health care and living expenses are about 50 percent of the average nursing home cost.

One solution

In January 1973, St. Vincent's Hospital in New York City started a program to bring professional health services to homebound, isolated and abandoned elderly people living in the Chelsea and Greenwich Village sections which surround the Hospital.

The goals of the program, known as the Chelsea-Village Program, are to keep patients:

- In their own community.
- Out of institutions.
- In adequate housing.
- In the best possible state of health.
- At the maximum possible level of independence.

Through this program we have shown that the concept works—that people who would otherwise have been forced into institutions can be maintained at home; and that money is saved. Our patients most of whom are semi-ambulatory, have total living costs, including health services, of $8,539 per year (in 1975 dollars). This compares with an average cost, using the methodology of the study, of $16,231 for similar patients in New York nursing homes.

In the first four years of the program, we have had experience with 466 individuals and made over 3,500 home visits. The average age of our patients is 80. Two-thirds are women. Two-thirds live alone.

The problems of our patients are complex and multi-faceted, involving not only physical and psychological disorders, but also difficulties with money, housing and social isolation.

Fulfillment of our goals requires a close working relationship among the hospital, local people and agencies. A strong community relationship is vital to a program of this nature, because the patients—isolated and often unable to call attention to themselves—can be found only by developing a comprehensive network of human contacts. Of our first 466 referrals, 288 were from community sources and 178 from the hospital.

Team operation

To provide the necessary services to the homebound, we use health teams consisting of a coordinator, physician, nurse and social worker. Their combined skills are often sufficient to provide practical assistance to patients in situations where any one health worker would fail. A homemaker is an important additional staff member of the program.

The coordinator is the contact with the patient or the referring community

Comparative Costs of Home Health Care and Nursing Home Care for One Year

	St. Vincent's Program*			Average Nursing Home		
	Ambul.	Semi-Ambul.	Bed-Bound	Ambul.	Semi-Ambul.	Bed-Bound
St. Vincent's Program						
Per Visit	$105.28	$105.28	$105.28	Costs not broken out		
Visits per year	10	11.1	14.8			
Cost per year	$1,053	$1,169	$1,558			
Program Comm. Health Aid						
Per visit				Costs not broken out		
Visits per year						
Cost per year						
NYC Housekeeping/Homemaker Serv.						
Per Visit	$17.20	$17.20	$17.20	Costs not broken out		
Visits per year (4 hrs. at $4.30 per hr.)	52	104	260			
Average cost per year	$894	$1,789	$4,472			
Cost for 24-hr. Home Attendant, 365 days/yr. at $33/day			$12,045**			
Visiting Nurse Service						
Per Visit	$24.02	$24.02	$24.02	Costs not broken out		
Visits per year	12	25	52			
Cost per year	$288	$601	$1,249			
Food	$1,440	$1,440	$1,440	Costs not broken out		
Rent	$2,190	$2,190	$2,190	Costs not broken out		
Other Costs	$1,170	$1,170	$1,170	Costs not broken out		
Mandated Physician Visits	Part of program			300	300	300
Total Nursing Home Costs						
Per nursing hour/year 1974				$7,376	$7,376	$7,376
Hours/day				1	2	4
Cost per year (1974)				$7,376	$14,751	$29,502
Add 8% inflation factor for 1975				$7,966	$15,931	$31,862
Total	$7,035	$8,359	$12,079	$8,266	$16,231	$32,162

**Using NYC housekeeper/homemaker services*
***$19,652 for 24 hr./day care (option)*

agency. Most referrals come by telephone. The coordinator makes and confirms appointments, answers inquiries, participates in team conferences, schedules visits, maintains charts and functions as a central source of information for patients and program members.

The social worker is concerned with obtaining concrete services for patients such as Medicaid eligibility, homemakers, change in housing and the initiation of Meals-on-Wheels. After the initial contact, counseling sessions are often arranged by the social worker.

The nursing aspect of the program is carried out almost entirely by one person, a member of the Sisters of Charity, who has worked full time for the program since its beginning. This nurse knows every patient and is the most consistent source of contact between patients and staff.

The physicians are recruited in part from hospital residents who volunteer time outside prescribed duties; others are paid by the hospital for their time in the program. Some physicians in private practice volunteer their services.

Teams see patients by appointment, and a social worker, nurse and physician are ordinarily present. About 27 home visits are made per week. Of these four are to new patients.

Since many of our patients fail to qualify for New York City-sponsored homemaker services or are subject to bureaucratic delays, we employ our own homemaker. Our homemaker is prepared to step in immediately to provide assistance. A prompt response is often critically important in avoiding a complete collapse of the home situation. We are often able to create a viable network of services that keep the patient safe and comfortable at home.

Conferences are held weekly to review problems and discuss both theoretical questions and matters of immediate patient care.

Desirability of a hospital base

Homebound elderly people require medical services from a physician and nurse, as well as social worker assistance, in order to maintain themselves independently at home with safety. Regular participation by physicians is likely only if the program is based at a hospital. Furthermore, subspecialty services required from time to time—the advice of a psychiatrist, urologist, dermatologist—can be tapped easily only when there is access to the pool of skills available in a hospital. In addition, if a patient becomes seriously ill, a hospital-based program has access to in-patient beds, can arrange for admission of a patient without delay and permits continuity of care.

Free-standing community agencies, no matter what their experience or background, are unlikely to be able to serve this group of people effectively. Agencies whose primary commitment is to homemaker services, visiting nurses or social service, cannot easily meet the complex needs of these individuals and merely create unrealizable expectations in their patients.

Standard home care departments, which presently exist in many major hospitals, are designed for other kinds of patients. Originally home care services were established to accelerate the transfer of in-patients to their homes when they simply needed additional nursing and/or physical therapy in order to return to normal activities. To meet the financial regulations for most home care services, patients must be identified within the hospital and be expected shortly to return to full activity. Further, staffs of most home care departments do not include physicians who make visits in the home. Unfortunately, homebound elderly patients are, by and large, not identified as in-patients, can rarely be expected to return to normal health and need physicians' services to meet their goals. They require long-term attention.

Case histories of patients

The cases encountered by our teams are often a mixture of medical and social problems. Two examples follow:

• M.M., a 73-year-old woman was referred to our program by a neighbor. She lives in a one-room, walk-up apartment. At our first contact she was found to be homebound due to heart failure and massive fluid retention.

She was confused and habitually defecated in kitchen pots scattered around the room rather than in the toilet. Her cardiac disease was treated with digitalis, diuretics and potassium, and our staff monitored her medication program daily. She lost 22 pounds of edema fluid.

Her need for human contact was met by the devoted interest of a community resident who began visiting her at our suggestion. He appeared every day, helped clean her apartment, and required her to eat, wash and groom herself. His demonstration of interest altered the patient's behavior strikingly. Her confusion faded as her life became significantly more structured.

She is now clean and uses the bathroom in the traditional manner. While she is still homebound, her heart failure has improved sufficiently so that she is comfortable.

• C.B. is a 67 year-old woman referred to us by a distant relative. She worked in an office until age 65, then retired, became a recluse and spent her time eating.

When first visited by our team on April 2, 1974, the physician noted: "Patient was able to open the door for us. She tripped, fell and couldn't bring herself to her feet. It took 15 minutes to figure out how to lift her. It was like trying to pick up a massive bag of jelly. She is obese to a remarkable degree. In addition, 3-plus edema. Pulse - 160, irregular rhythm. BP - cuff not big enough. EKG - rapid atrial fibrillation."

The patient agreed to hospitalization. It required four men from the ambulance company to carry her downstairs. Weight recorded in the hospital was 335 pounds. After five weeks she was returned home weighing 280. She was placed on a medical regimen of digitalis, diuretics, insulin for her newly-discovered diabetes mellitus and a sodium-restricted, 1,200-calorie diabetic diet.

Over the next 15 months, under our close observation, the patient's weight fell steadily and her medical disorders remained stable.

Our physician noted on August 14, 1975: "Weight 196. Patient goes out once a week. Able to climb stairs without assistance. She agreed to help in our program by providing telephone reassurance to another patient each day."

A social service note on January 30, 1976: Patient is improved and no

St. Vincent's Home Health Care Program

Type of Visit

	Initial with M.D.	Initial w/o M.D.	Routine Follow-Up 0-60	61-70	71-80	81-90	90+	Specific Purpose	Total
Number of visits	85	9	85	151	357	292	56	105	1140
Team hrs./visit	1.58	1.36	1.09	1.09	1.24	1.39	1.54	1.06	1.27
Total team hrs.	134.30	12.24	92.65	164.59	442.68	405.88	86.24	111.30	1450

Fixed Budget Costs of Program

Fixed Salaries

Project Director	$ 7,550
Supervisor	6,338
Co-director	2,112
Coordinator	12,368
Social Worker-Admin.	2,361
Typist	500

Fixed Portion of Visits

Nurse (317 hrs. at $9.72)	3,081
Social Worker (304 hrs. at $11.23)	3,413

Fixed Expenses

Laundry and Linen	$ 60	
Depreciation	370	
Deprec. Equip.	82	
Oper. & Maint.	370	
Housekeeping	1500	
Share of Cafe	100	
Nursing Admin.	420	
Gen. & Admin.	2618	
Hsg. Allow.	1500	
Soc. Service	1650	
Office Supplies	800	
Meetings & Publ.	500	
Telephone	200	

x 1.08 (1975 $)									13,219
Total									50,942
Team Hours									1,450
Rate/Team Hour									35.13
x Team Hours/Visit	1.58	1.36	1.09	1.09	1.24	1.39	1.54	1.06	1.27
Fixed Cost/Visit	55.51	47.78	38.29	38.29	43.56	48.83	54.10	37.24	44.62

Variable Costs per Visit

Visit-Site

Sal. & Fringes Nurse ($9.72/hr.)	14.59	13.22	8.05	7.95	9.16	10.27	11.38	8.76	9.72
Social Worker ($11.23/hr.)	15.96	15.27	6.12	7.34	8.36	7.80	4.32	2.38	7.80
Physician ($26.69/hr.)	42.17	0	22.11	21.82	24.82	28.57	31.65	23.20	26.49

Office Related

Nurse (.26 hr./visit)	2.53	2.53	2.53	2.53	2.53	2.53	2.53	2.53	2.53
Social Worker (.38 hr./visit)	10.89	10.89	3.82	3.82	3.82	3.82	3.82	2.47	4.29
Physician (.038 hr./visit)	.77	.77	.77	.77	.77	.77	.77	.77	.77
Consulting Physician ($26.69/hr.)	0	0	2.61	2.61	2.97	3.33	3.69	2.54	2.74

Variable Expenses

Van Costs ($.20/mi.)	.40	.40	.40	.40	.40	.40	.40	.40	.40
Medical Records ($.80/call)	.80	.08	.20	.20	.20	.20	.20	.64	.29
Lab Service ($6.05/occ.)	1.01	1.01	1.01	1.01	1.01	1.01	1.01	1.01	1.01
Medical Supplies ($.34/visit)	.34	.34	.34	.34	.34	.34	.34	.34	.34
Telephone ($.19/visit)	.19	.19	.19	.19	.19	.19	.19	.19	.19
Office Supplies	.20	.20	.10	.10	.10	.10	.10	.10	.11
Misc. at 5%	4.49	2.25	2.41	2.45	2.73	2.97	3.02	2.27	2.83
Variable Cost/Scheduled Visit	94.34	47.15	50.66	51.53	57.40	62.30	63.42	47.60	59.51
Missed Visit Allowance	1.84	.91	.98	.99	1.11	1.21	1.23	.92	1.15
Variable Cost/Actual Visit	96.18	48.06	51.64	52.52	58.51	63.51	64.65	48.52	60.66

Summary

Variable cost/visit	96.18	48.06	51.64	52.52	58.51	63.51	64.65	48.52	60.66
Fixed cost/visit	55.51	47.78	38.29	38.29	43.56	48.83	54.10	37.24	44.62
Total cost/visit	151.69	95.84	89.93	90.81	102.07	112.34	118.75	85.76	$105.28

longer needs us. About to start a trip on a freighter through the Panama Canal to California, fulfilling a lifelong ambition.

Financial support

The Chelsea-Village Program is supported by money we have raised from grants. These are short-term funds which come primarily from private philanthropic agencies and, to a lesser degree, from the New York City Department of Health.

We do not accept money from patients, for two reasons. First, they are by and large impoverished and unable to pay for services. And second, we feel it is antithetical to establish financial barriers to care, when our major objective is to overcome barriers between patients and the health system.

Although almost all of our patients are covered by Medicare and a significant number by Medicaid as well, we are not able to obtain reimbursement from these sources. When Title XVIII and Title XIX legislation was written in the 1960s, reimbursement for home health services was largely omitted. Payment for home visits by nurses and for some forms of homemaker services is allowed, but not if they are hospital employees.

Hospitals may not bill for care by staff who render services outside the hospital's walls, unless the hospital has a home-health agency certified under Title XVIII. Even with certification, the extent of care hospitals are allowed to provide is inadequate for these patients.

If hospital-based programs such as this are to be established across the country, Medicare and Medicaid legislation must be amended.

Comparison of costs

Health planners and legislators must have accurate cost measures of home health care service and nursing home care in order to develop public policy.

In 1975 the Florence V. Burden Foundation provided funds for a thorough cost analysis of a home-health care program, by Boehringer Associates, using the Chelsea-Village Program of St. Vicent's Hospital as a model.

This study produced an expense comparison between home health services and nursing home care. Time-motion research techniques were used to measure the actual costs of the Chelsea-Village Program on a yearly cost-per-visit basis. To this were added estimates of food and rent costs, and the value of typical ancillary services (homemakers, Meals-on-Wheels, and so forth) required by patients.

Forty-seven home visits were observed to determine differences in time and resulting costs. The length of time per visit did not vary significantly with the patient's physical disability, interval between visits or number of team members present. From the data, three types of visits related to time were identified: initial, follow-up and specific purpose.

The initial and specific-purpose visits were each associated with distinct time durations. In the follow-up category, the length of the visit increased with the age of the patient.

The actual time spent with the patient is, of course, only one component of the total visit time. Elements of preparation and travel are common to all visits.

Based on the study, it is projected that our average visit will take 1.27 hours, travel included.

In this study, there was an average of 10 visits per year for ambulatory patients, 11.1 visits for semi-ambulatory patients and 14.8 visits for bedbound patients. The patients in the program are, in general, semi-ambulatory.

The per visit cost of the Chelsea-Village Program, if the projected forecast holds true, is $105.28.* This cost will decrease as the patient base widens, to the point where the fixed costs must be increased, probably in late 1977. Monitoring of patient visits, staff time required and cost keeping are evaluated continuously so that staffing requirements and expense levels can be adjusted to the census.

The average patient is visited about 11.1 times a year, producing an annual visit cost of $1,169.

Nursing home costs were established through a sample of 23 homes in the New York City area, by a regression analysis, using statistical and financial reports submitted to the New York State Department of Health.

To determine whether or not the patients in the program were, in fact, candidates for nursing home care, an expert panel of physicians with experience in ambulatory care was asked to review a sample of 29 cases. Six patients were rejected because they were considered well enough for standard, outpatient care and/or there was enough family support at home to provide the necessary services without significant additional help. The remaining 23 patients would be candidates for nursing home care, if the Chelsea-Village Program were unavailable. Twenty patients were classified as being semi-ambulatory and three as bedbound. General nursing care required averaged 2.75 hours per patient daily.

The New York State hospital code mandates specific nursing care hours for patients in nursing homes, depending upon degree of disability. The cost of one hour of nursing care in a nursing home over a year, including all operating expenses, was $7,375.62, according to data derived from the New York State Department of Health. The average cost of a Chelsea-Village Program patient, if placed in a nursing home, based on 2.75 hours of nursing care per day, would be $20,283 per year.

In reality, the reimbursement system used by Medicaid prescribes a fixed daily rate, which includes all types of patients. The rate is calculated by dividing the approved yearly operating costs of the home by patient days. The average daily Medicaid reimbursement rate reported by the nursing homes in the sample was $41.65, or approximately $15,200 per year per patient, regardless of degree of care. This indicates that the ambulatory patients in a nursing home are subsidizing the bedbound patients.

In summary, semi-ambulatory patients in the Chelsea-Village Program can be maintained at home for slightly more than half the cost of nursing home care for the same people.

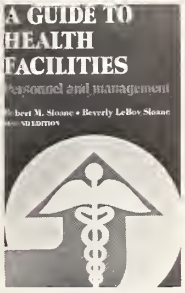
Hospital-based home health care programs should be encouraged throughout the country. The potential benefit to individual elderly people and to the community at large is significant. ■

** A detailed financial analysis may be obtained from the Florence V. Burden Foundation, 630 5th Avenue, N.Y. 10020.*

Publications and Films

Please address all inquiries and requests for publications and films to the addresses in the listings. Items for review should be sent to Darlene Young in care of this magazine.

A Guide to Health Facilities: Personnel and Management. Robert M. Sloane and Beverly LeBov Sloane. The C. V. Mosby Company, 11830 Westline Industrial Drive, St. Louis 63141. $6.95



The first section of this work describes the history and development of health facilities. Contemporary facilities are described with reference to major technologic contributions.

Section two follows with a presentation on functions, personnel, and interrelationships of various departments within health facilities.

The third section is devoted to management, with emphasis on supervision, scientific analysis, work simplification, and management by objectives.

Automation and the future of health facilities are covered in the fourth and fifth sections.

Hospital Management Systems: Multi-Unit Organization and Delivery of Health Care. Montague Brown and Howard Lewis. Aspen Systems Corporation, Dept. BL, 20010 Century Blvd., Germantown, Md 20767. $17.50

This book details 27 case histories of hospital systems in all parts of the country and includes information on how to:

- Develop and implement a hospital system that will be flexible in case of change.
- Acquire the most up-to-date technical innovations.
- Increase utilization of clinical laboratory facilities while cutting costs.
- Make physicians more available to isolated rural areas.
- Gain the support of the community.
- Make use of empty beds.

Evaluation of the Impact of PHS Programs on State Health Goals and Activities: Final Report. Office of Planning, Evaluation and Legislation, Div. of Evaluation, Health Resources Administration, Rm. 1022, 3700 East West Highway, Hyattsville, Md. 20782.

Findings, conclusions and recommendations resulting from a pilot study of the impact of selected Public Health Service (PHS) programs on health goals and activities of the states are presented.

The report is organized into: an introduction and synthesis of key findings; three chapters that detail state goals, state uses of program resources, and federal impact; a discussion of state-regional office relations; and conclusions and recommendations.

The Impact of Public Health Service Programs on State Government: Annotated Bibliography. Office of Planning, Evaluation and Legislation, Div. of Evaluation, Health Resources Administration, Rm. 1022, 3700 East West Highway, Hyattsville, Md. 20782

This bibliography is the product of an extensive search of literature relevant to the implementation of federal health programs.

The program areas studied included:

- Health planning
- Community mental health centers
- The cooperative health statistics system, and
- Nursing training grants.

The literature search was also concerned with the implementation of federal health programs and intergovernmental relations generally.

Medical Peer Review: theory and practice. Paul Y. Ertel, M.D. and M. Gene Aldridge. C.V. Mosby Company, 11830 Westline Industrial Drive, St. Louis, 63141. $25.00

This book focuses on those aspects of health care and its evaluation that will be as important tomorrow as they are today, such as the principles of peer review and facts about operative review systems.

Part one of this publication traces the evolution of medical practice, social values and attitudes toward health care. Examples of operating systems peer review are presented in Part two.

Part three presents those aspects of peer review about which there are a reasonable measure of agreement. A glossary of terms and list of abbreviations common to peer review is included.

Too Old, Too Sick, Too Bad: Nursing Homes in America. Frank E. Moss and Val J. Halamandaris. Aspen Systems Corporation, Dept. T, 20010 Century Blvd, Germantown, Md 20767. $15.95

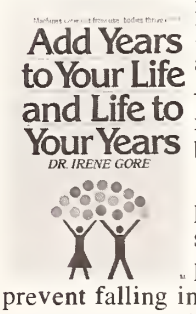
The focus is on problems confronting the professional trying to do a good job with limited resources. The book reviews each area of nursing home care from the point of view of the administrator.

Part I details what happens in nursing homes. What are the most prevalent problems? Are abuses isolated occurrences or common industry practice? Part II explains why it happens, discussing the root causes of nursing home abuses.

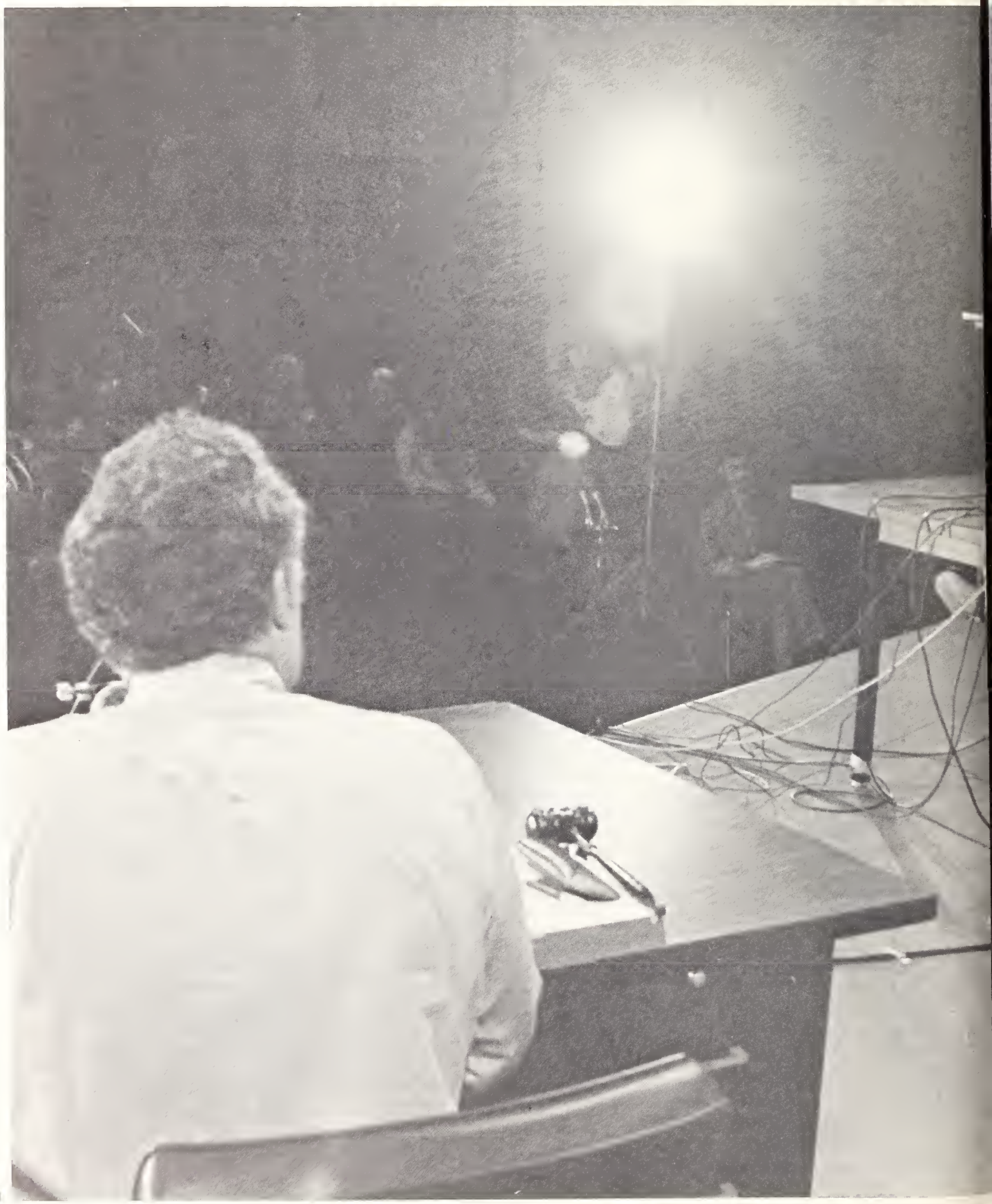
Part III discusses what makes a good nursing home and Part IV suggests practical ways for improving nursing home care.

Add Years to Your Life and Life to Your Years. Dr. Irene Gore. Stein and Day Publishers, Scarborough House, Briarcliff Manor, N.Y. 10510. $1.95 paperback

The good news in this book is that individuals can add life to their years — and years to their life — simply by doing more, not less, with body and mind.



Dr. Irene Gore provides practical suggestions on steps people can take to prevent falling into the ruts of getting old: exercise, diet, relationships, attitudes, and physical and mental activity.



HEW Holds Hearings on National Health Insurance.

After nearly a half-century of discussion about national health insurance and a raft of legislative proposals for various forms of it, HEW Secretary Joseph A. Califano, Jr., directed that public hearings on the subject be held throughout the country as a prelude to formulating a legislative proposal. The Secretary chaired the first hearing in Washington on October 4, and more than 70 persons representing a wide range of viewpoints testified. Excerpts of the hearing follow:

SECRETARY JOSEPH A. CALIFANO, JR.: After more than 40 years of debate and discussion, we are getting down to the business of creating a system of national health insurance for our people.

The public has indicated that it wants national health insurance. The health industry has indicated its willingness to participate in an insurance plan. Congress is ready to debate national health insurance. The President has promised to develop a plan and submit it to the Congress in 1978.

But most important, our people need national health insurance. Even the affluent cannot afford the high cost of health care much longer. Ultimately, this nation must have a system which will assure the financing of health care for all our citizens; a system which will promote a more equitable distribution of health care services for our people; and a system which will bring our health care costs under control.

Let me emphasize that we have made no decisions about the details of the national health plan we shall recommend to President Carter. The President has, however, outlined basic principles or goals for NHI. Among them are:

- The plan must include preventive health care services.
- Coverage must be "universal and mandatory," with "comprehensive benefits."
- It must be manageable and affordable.
- It must contain "strong and clear built-in cost and quality controls."
- Consumers must participate in its development and administration, and in decisions about health care services.
- The plan must be phased into operation at a realistic rate, and it must be compatible with our welfare reform plan.

We are seeking the best advice and counsel we can find. Our 10 regional offices will conduct nearly 100 public hearings and meetings in towns and cities across the country throughout the month of October.

Earlier this year, I appointed an advisory committee on national health insurance issues. That group has held a series of regional site visits to examine problems of health care financing and delivery and will hold additional meetings in Washington before giving us their advice later in the fall.

Now, to today's business.

"If we pass comprehensive health insurance, or if we do nothing, it is not going to make very much difference in terms of the taxpayers' pocketbooks. It is going to cost pretty much the same."

SENATOR EDWARD KENNEDY *of Massachusetts:* The myth which we hear most frequently is that this country can't afford a comprehensive health insurance.

This country has recognized in recent times that when we deal only with the financing of health delivery systems, we fail. We must have a comprehensive systems approach that will ensure that quality health care will be available in the multiple forms that are included in the health security program. That will take into account the details of cost controls and management problems which you have outlined here.

You have put stress on preventive health care, which is so important to the American people, certainly in terms of good health habits. But the fact of the matter is, if you break your leg or need prenatal care, just having good preventive health care isn't going to deal with the problem. There is only one bill that stresses, in addition to preventive health care, cost controls and limitations; assures quality; recognizes the importance of allocation of resources and health personpower across this country; and is really going to get a handle on expenditures. That is our health security program.

We are the only industrial society, outside of South Africa, that doesn't have comprehensive health insurance. Canada has been able to put an effective ceiling—in terms of allocations, resources and GNP—on health care costs. They have problems, no question about it, but it is functioning and working. You can ask any senior citizen, any worker, any expectant mother in Canada, or any of the people who live in the rural areas of Canada, and ask any of the politicians in Canada, and you won't find any who want to go back to a health care system like what we have here in the United States.

We have the very best in many different phases of our health care system. We have to build on those. But only if we have a health security program will we be able to do so.

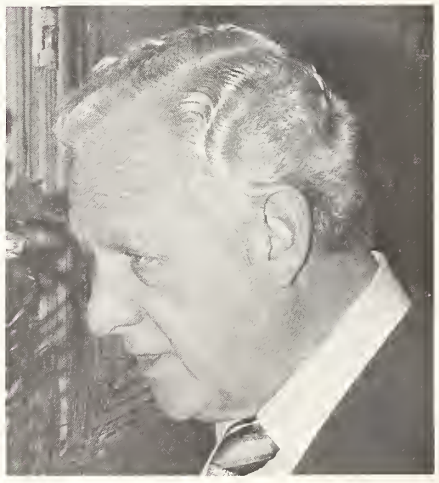
Twenty million Americans have absolutely no health insurance. The interesting part is, even if you have health insurance, you may find out what a small percentage that insurance actually pays. You still pay 40 percent when you are covered for physicians' services. If you have dental services, you are fortunate to be one of 16 percent of the American people who do; but you still end up paying 81 percent out of pocket. And with drugs, which are so important, particularly to senior citizens, 84 percent of expenditures are paid out of pocket on the average.

SECRETARY CALIFANO: Senator, it is often charged that the health security legislation or legislation like that will cost the American people tremendous amounts of money. Would you comment on that?

SENATOR KENNEDY: Certainly. We expended $140 billion last year for health care costs in the nation. The Congressional Budget Office and your Department in evaluating the AMA program, the Hospital Association's program, and the insurance program—all estimates came within about $30 billion of the $250 billion by 1981 of total health insurance expenditures.

If we pass comprehensive health insurance or if we do nothing, it is not going to make very much difference in terms of the taxpayers' pocketbooks. It will cost pretty much the same.

"To the extent we provide access to dental care for those people who need it most—the needy and medically needy—it is a piecemeal, haphazard and largely ineffective effort."



DR. FRANK BOWYER, *president of the American Dental Association:* First, I do not appear here today in any sense an adversary to your efforts, but rather to offer the resources of the American Dental Association, which represents over 127,000 mem-

bers across this nation, to work with you in establishing a partnership in health that can accomplish our mutual objectives.

With all due respect to this and previous administrations and government at all levels, to the extent we provide access to dental care for those people who need it most—the needy and medically needy—it is a piecemeal, haphazard and largely ineffective effort.

With very few exceptions, dental care benefits under Medicaid, including the Early Periodic Screening, Diagnosis and Treatment portion, range among the states from practically nothing to less than adequate.

SECRETARY CALIFANO: We proposed changes in the EPSDT program to try to reach more children with medical and dental care.

DR. BOWYER: This unhealthy state of affairs might have been avoided or at least ameliorated if recommendations of the American Dental Association had been heeded years ago, particularly during and since the early 1960s.

SECRETARY CALIFANO: Would you want all dentists covered in a national health insurance program?

DR. BOWYER: Sir, dentistry is certainly part of total health care and we would want dental services to be covered, but we could not concur with a program that was totally funded for every person in this nation from Federal revenues, nor one that is totally administered by the Federal Government. That would be the bottom line.

SECRETARY CALIFANO: So long as it is not totally administered by the Federal Government and part of the money comes from non-Federal revenues or from the private sector, would you have any objection if there is Federal-state sharing?

DR. BOWYER: No, sir; not at all.

"For a country that prides itself on being the richest, the most democratic, the most concerned, the fact that we are way down the line in terms of health security makes me feel a little ashamed as an American citizen, when I go abroad to countries that have less, but do more for all of their people."

Ms. EVELYN DUBROW, *legislative representative of the International Ladies' Garment Workers Union:* First of all, I have been working on health insurance since the Murray-Waggoner-Dingell bill days. That may even be before your time, Mr. Secretary.

Second, for a country that prides itself on being the richest, the most democratic, the most concerned, the fact that we are way down the line in terms of health security makes me feel a little ashamed as an American citizen, when I go abroad to countries that have less but do more for all of their people.

Third, I would like to say we have now been working for many years for S. 3 and H.R. 21, the Kennedy-Corman bill. We are doing it because we think that health care is a right, not just a need.

You may want to phase in on those who are the most needy, the senior citizens, the children, people on certain levels that do not get help. Those who are below the poverty level sometimes get better health care than those in the great in-between, the middle class and the well-to-do.

SECRETARY CALIFANO: If I understand you correctly, you would complete the coverage of senior citizens and then go after the children next?

MS. DUBROW: The children and those who do not have any kind of protection. But for a union which 60 years ago established the first medical health center and has probably negotiated more health programs for a longer time than any other, we are telling you now that it is almost impossible to continue the program that we have established for the many thousands of our workers.

And I suggest that we are just an example of the problem that occurs. Our employers find they cannot increase the health programs that we have. On the other hand, the health costs go up all the time. So we find people in the union are getting less health care now than 20 years ago, because of the administrative costs.

We must forget a piecemeal type of program. We must have a national health security program that will be an employer-employee contributory program, that the Federal Government will pay out of general revenue and that will not be left to the private sources who have done such a terrible job so far.

"There should be uniform and comprehensive benefits for all."

DR. WILLIAM C. FELCH, JR., *chairman of the American Medical Association's Council on Legislation:* The AMA has presented its views on national health insurance over a long period of time. It introduced legislation starting in 1970 and in recurring sessions of the Congress since that time.

The present AMA program would make comprehensive private health insurance available to all persons, regardless of income. The benefits are comprehensively broad, covering full hospital care, full physician care (wherever provided, both in and out of the hospital), home health services, emergency care, lab and x-ray services, extended care services, etc.

SECRETARY CALIFANO: In terms of simple administration, to the extent the Government is involved, would you have administration only at the Federal level?

DR. FELCH: If there were to be only one level of government administration, I suspect the AMA would prefer to have administration by state government. The thrust of the bill is to keep it in the private sector.

The AMA has developed a list of principles about national health insurance embodying the notion that there should be uniform and comprehensive benefits for both employed and nonemployed. This includes a broad range of benefits, hospital care, home health services, realistic preventive care, psychiatric treatment and the full range of dental care for children, for all.

SECRETARY CALIFANO: Who would pay for the unemployed or the poor under that system.

DR. FELCH: The Government would pay that.

SECRETARY CALIFANO: Would you define the poor in a realistic way in terms of, say, the Bureau of Labor Statistics standards for an urban family as distinguished from the poverty level?

DR. FELCH: Yes, the bill has figures. We will supply them for you.

SECRETARY CALIFANO: So, you would bring in about 20 or 30 million more Americans under the Federal Government?

DR. FELCH: On a sliding scale, it would cover all Americans.

SECRETARY CALIFANO: You would have the Federal Government cover all poor people, with a realistic definition of poor.

DR. FELCH: That is correct, and on a sliding scale the Government would pay a percentage of premiums.

SECRETARY CALIFANO: So, you would not be cut off if you started to make a little more money.

DR. FELCH: Yes. The level of Federal assistance we have talked about, we think should be provided on the basis of need, and for the poor the subsidy would be the full premium cost.

SECRETARY CALIFANO: Does the AMA have any objection to this program covering the services of paramedicals or employing paramedicals wherever possible to do the work it is not necessary for doctors to do?

DR. FELCH: The AMA has always endorsed coverage of the services of paramedical people, providing they are supervised in the delivery of those services.

SECRETARY CALIFANO: But in terms of paramedical people out in rural areas where there are no doctors, do you have any objections to covering that situation?

DR. FELCH: If they have connections with doctors. We think that medical care has to be flexible. That means that patients have to have the maximum freedom to choose their own form of care, and each individual would retain these basic rights to choose his or her own form of health insurance coverage.

SECRETARY CALIFANO: His or her own doctor?

DR. FELCH: Yes.

SECRETARY CALIFANO: Everyone would have a right to choose their doctor. Would you have any objection to doctors publishing what they charge for various services, so a patient could compare the charges?

DR. FELCH: I would have no objection to that. In summary, then, the AMA proposals would make health care available to all Americans regardless of income. Most individual coverage would be provided through the employment and the total premiums would be shared, with the Government premium sharing limited to those in need.

SECRETARY CALIFANO: Is your purpose for having individuals share premium costs to affect utilization or simply to ease the costs?

DR. FELCH: To ease the costs to the Federal Government.

SECRETARY CALIFANO: Are you aware of any indications that the cost-sharing affects utilization?

DR. FELCH: At a premium level, I am not aware of anything.

"The promise of Medicaid and Medicare has really not been met. We have promised more than we can deliver. In my own state, the Medicaid level has not been raised since 1966."

"In this country, we have a sick policy, we don't have a health policy. We are dealing with people after they have gotten ill."

ROSALIE SILBER ABRAMS, *Maryland state senator, representing the National Conference of State Legislatures:* I am also the principal sponsor with Senator McGuirk of the Health Services Review Commission legislation which I am sure you are familiar with and which we feel is doing a very effective job.

SECRETARY CALIFANO: Yes, and that is part of what we used as a model for Federal legislation.

SENATOR ABRAMS: It is heartening to see that it is really working extremely well. We have not seen a diminution of quality at all.

I serve on the board of one of the largest public hospitals in the state, and contrary to what you might expect, limiting costs is not going to limit quality. What we have done is to require every hospital to study how effectively they are providing services. In prior years, they felt they had almost a carte blanche, expecting any deficits they incurred would be picked up by their charities or public funding.

When the beds are there and the surgeons are there, we are going to operate on people. Everything has a relationship to everything else.

SECRETARY CALIFANO: Have you had any success in Maryland in closing down excess hospital beds?

SENATOR ABRAMS: It is tough to do. Everybody wants the pediatric unit and an OB unit. The administrator of an inner-city hospital said that, if he met every OB patient at the door of the hospital and gave each $500 and cab fare to another hospital, he could save money.

The point I want to make for the National Conference is that the states are a reservoir of important information because we have already been doing many of the things you are talking about. We are anxious to have you look at those experiments, to see what Maryland has done, to see, for example, what Maine has done with catastrophic health insurance.

SECRETARY CALIFANO: You mentioned catastrophic coverage. If there had to be a phase-in, is that the coverage you would phase in first?

SENATOR ABRAMS: We believe catastrophic coverage ought to be one of the programs phased in first. We also believe there should be more emphasis on preventive care, even if it means merely providing immunization for children. That would be a beginning.

But there ought to be emphasis on preventive care and, at the other end, you have to deal with the elderly, because they are the ones who are suffering, I would guess, most severely today.

The promise of Medicaid and Medicare has really not been met. We have promised more than we can deliver. In my own state, the Medicaid eligibility level has not been raised since 1966.

SECRETARY CALIFANO: Has the conference thought about how responsibility under the national health insurance program would be distributed among the different levels of government?

SENATOR ABRAMS: We think the States ought to pay a part of the cost of national health insurance. We believe the responsibility for regulation belongs in the states. The states are actively involved in delivering services and doing many of the things that national health insurance would require as far as quality control.

We believe that at the very least the administration ought to be left with the states, particularly as far as regulation and licensing are concerned, and I think they ought to co-pay.

Let me briefly talk about two other things. We now have a sick policy in this country, we don't have a health policy. We are dealing with people after they have gotten ill. If we have limited dollars, they can be spent most effectively through education—trying to get people to change their lifestyles, to stop smoking, to deal with and prevent overweight problems, among others.

The other issue we have to deal with is changing from fee for services, which is an open-ended fiscal problem.

SECRETARY CALIFANO: Would you have salaried doctors?

SENATOR ABRAMS: I think we ought to have both. I think we need the private model and the public model. I think we need some group practices and some prepaid ones—there are obstacles to prepayment in the laws of many states.

We would also like to see dealt with, and this is important from my personal point of view, the other things that cause illness and disability—injuries, alcohol, industrial pollution and automobile accidents, to name just a few.

"I would much prefer to have the employees pay part of the premium and also pay for part of the benefit, because human nature being what it is, they are more interested if they pay a portion of the cost."

ROBERT F. FROEHLKE, *President of the Health Insurance Association of America:* I represent an association of 310 companies that write approximately 85 percent of the commercial health insurance in the country.

The HIAA has for the better part of the decade supported what is now called the McIntyre-Burleson bill, H.R. 5 and S.5. We believe this is most responsive to the public need and to the kind of society we have and to the kind of people we are.

We think this recognizes that we are, in a sense, our brother's keeper and we have a social responsibility. We also recognize that we are rather individualistic and, to the extent we can, we want to be self-reliant and free.

A tax-supported nationalized health insurance program could cost, if it were comprehensive, at least $80 billion in additional taxes. In my opinion this is not in the picture for the near term because of practical political considerations. We believe we can achieve the goals that the proponents of a tax-supported nationalized insurance believe they can, but not by using tax dollars except where absolutely necessary. And if you are going to take the phased-in approach, wouldn't it make sense to take the least tax money, the least disruptive program, and determine whether or not it will work? The main feature of our plan is that government set minimum standards for comprehensive health insurance benefits.

SECRETARY CALIFANO: For the employers to provide the employees?

MR. FROEHLKE: And for individuals who are not working for employers to get individual policies.

SECRETARY CALIFANO: Would you let the employer and employee work out who pays the premium?

MR. FROEHLKE: Yes.

SECRETARY CALIFANO: If Congress mandated that employers provide it, that would be fine so long as the premiums went to the insurance company?

MR. FROEHLKE: I would much prefer to have the employees pay part of the premium and also pay for part of the benefit, because human nature being what it is, they are more interested if they pay a portion of the cost. It shouldn't be too great a portion.

SECRETARY CALIFANO: Do you have any indication that having an employee or an individual pay either part of the premium or deductible has an impact on utilization?

MR. FROEHLKE: I think I can submit some studies that would indicate there is less utilization if the individual pays a portion.

"It is really a crime that our physicians in this country have a tremendous talent in developing technology, but that technology doesn't get to the poor people."

DR. BERNARDO BENES, *president of the American Health Planning Association:* I believe that anything the Government wants to do in national health insurance has to go hand-in-hand with the local, state and national entities in planning. It is really a crime that our physicians in this country have a tremendous talent in developing technology, but that technology doesn't get to the poor people.

SECRETARY CALIFANO: Do you think we need more doctors?

DR. BENES: I think so. We also need more physician assistants. Many

medical professionals are strongly opposing the physician assistants and nurse practitioners.

I have listened to many sides. The Republic of Costa Rica in the last three years has instituted national health insurance with no money, but with a tremendous effort. They have done this fantastically well in a society of openness.

I have read the Kennedy-Corman bill, and I am appalled to see that psychiatric mental health is pulled out. Americans cannot be happy that the rate of suicide is going up and the rate of coronary problems is going down.

I don't know why every hospital in America gets seven or eight bureaucratic inspections. One good inspection with carbon copies to different agencies might be good enough.

Conservative people in America say that this is socialized medicine, because the government is paying 12 percent of the bill now. The best mechanism we have is the local Health Systems Agencies. If it were not for the HSAs, we would have 2,500 more beds in Miami today than two years ago. This is cost containment.

"The failure to provide comprehensive pharmaceutical service is like expecting a surgeon to operate without a scalpel."

DR. WILLIAM S. APPLE, *executive director of the American Pharmaceutical Association:* Prior administrations and the Congress have failed to recognize that a comprehensive approach to pharmaceutical services, including the drug products dispensed by the nation's pharmacists, is a necessary component of a quality health care system.

SECRETARY CALIFANO: Did they fail to recognize it or just didn't think they had the money for it?

DR. APPLE: There are essential drugs in both the acute and chronic care categories, which would have to be covered.

SECRETARY CALIFANO: If you were moving in terms of population, would you cover the old people first or the young people? I realize you would like to cover everybody.

DR. APPLE: We would recommend concentrating on coverage of the elderly and children.

SECRETARY CALIFANO: What would you do to control the prices of drugs if the Federal Government covered them all? Would you have the Federal Government set the price?

DR. APPLE: HEW, as a matter of fact, instituted a "maximum allowable cost" policy which we strongly supported before Congress. Unfortunately, it went astray in the implementation process.

SECRETARY CALIFANO: That is what everyone says about HEW programs. But how would you feel if you are covered? Would you have any objection to the Federal Government controlling the price?

DR. APPLE: We have advocated that the Federal Government insist that pharmacists be prudent buyers. To be a prudent buyer you have to know the market place and we have advocated that the MAC program require the manufacturer to publicly disclose what he is going to charge.

Failure to provide comprehensive pharmaceutical service is like expecting a surgeon to operate without a scalpel. Congress and the Administration must recognize that total patient care cannot involve the tradeoff of one component of health care for another.

"Medicare gave the medical profession the right to escalate its usual and customary fees, and that is what has happened —and that has promoted hospitalization. The more you bleed patients, the more you can charge; the more you X-ray, the more you can charge."

DR. FRANK FURSTENBERG, *executive associate for program development, Sinai Hospital of Baltimore:* What we need now is a comprehensive health care program of quality for all Americans without limitations due to age, inability to pay, residence, previous illness or employment status.

What we need is a sensitive, single-class system of health care, using appropriate providers and indicated resources and facilities.

SECRETARY CALIFANO: It is often said that, if we have a national health insurance plan of the kind you are talking about, doctors won't be as good as they are now. What is your view of that?

DR. FURSTENBERG: The answer to that is "hogwash." England is still producing very good physicians. We are recruiting them as fast as we can to take positions of eminence in this society. Canada is producing good physicians. Sweden has a great health care system. Norway has a good health care system.

Medicaid has too often provided poor care for poor people, due to its regulations, paperwork and low fees. Physicians refuse to participate. I, Mr. Secretary, do participate, but I am unhappy watching these patients ill at ease, uncomfortable, coming into my office under the regulations that do not allow me to treat them as I do the rest of my patients.

If I just had a Medicaid practice, I could not give quality care, due to its inadequate compensation. Medicaid fosters unnecessary visits to physicians, and I think it has led to fraud in this instance.

Medicare, on the other hand, was mandated to meet the needs of the elderly, but did nothing to change the health care system. Medicare gave the medical profession the right to escalate its usual and customary fees, and that is what has happened—and that has promoted hospitalization. The more you bleed patients, the more you can charge; the more you x-ray, the more you can charge.

"National health insurance legislation must specifically support the Indian Health Service or continuation of the Indian Health Service tribal urban Indian health system."

JOHN BELINDO, *executive director, National Health Board, Inc.:* On the basis of a unique legal, historical and moral relationship with the Federal Government, the Indian people now receive their health care from the Indian Health Service of HEW.

A broad-based national health insurance program cannot by itself deal adequately with the very special and unique cultural, linguistic, economic and geographic needs of the Indian people. I think the first important principle is that national health insurance legislation must specifically support the Indian Health Service or the continuation of the Indian Health Service tribal-urban-Indian Health system as the special Federal mechanism for financing and delivering health services to Indians.

Two, Indian people should be exempt from any compulsory national health insurance financing charge.

Three, the individual is entitled to the guaranteed benefit package in the

national health insurance approach, and prospective funding to implement the guarantee should be incorporated into the IHS system in conjunction with the adoption of national health insurance.

Four, tribal governments must be recognized as the appropriate governmental entities for the administration of health programs on their reservations.

Five, the principles of Indian self-determination must be incorporated in the national health insurance corporation.

Lastly, the urban Indian health programs must be designated as eligible providers for the purpose of receiving reimbursement from both Indian Health Service and national health insurance, when those clinics provide covered services to eligible persons.

We see this, the Indian Health Service, as a health care delivery system and financing system for Indian people.

[redacted]

"We would urge reversing the trend of placing all health care in the hands of private entrepreneurs with open-ended programs for which the providers set the price, with little or no controls on the costs or standards of care."

FRANCES KLAFTER, *representing the national Gray Panthers:* We believe the only plan proposed so far that will provide health care to all the people is the National Health Service Act, as proposed in H.R. 6894.

The Gray Panthers are convinced that health care needs of the elderly and the people of all ages can be met only by removing the profit motive from health care delivery by eliminating the fee-for-service system and establishing instead a national community-based health service.

We therefore, favor the establishment of a national health service embodying the principles contained in the Dellums bill. Such a service would establish free health care as a right of all people. The bill provides all those components and essentials in the kind of health care needed, not only for the elderly, but for all age groups in the population. It would require each community board to provide general primary care and treatment, including diagnostic, radiological, preventive health services, vision and hearing testing, and examination and provision of eyeglasses and other visual aids and hearing aids, home-health services including in-home medical diagnosis and treatment and all other services necessary to meet the health needs of people of all ages.

We would urge reversing the trend of placing all health care in the hands of private entrepreneurs, with the taxes of the people supporting open-end programs for which the providers of health care set the price, with little or no controls on the costs or standards of care.

The Kennedy-Corman bill, like the Dellums bill, meets most of the criteria we consider to be of prime importance in measuring the possible effectiveness of a national health plan. However, we part company with Kennedy-Corman on two very important issues. It does not provide for control at the community level and, although the bill has some provision for cost and quality controls, it would not exclude profitmaking for health care as would the Dellums bill.

SECRETARY CALIFANO: Do you mean you would not permit anyone to make any profit?

MS. KLAFTER: We think that a fee-for-service system can't meet the health needs.

SECRETARY CALIFANO: Would you have the Government set the price of everything?

MS. KLAFTER: It would be free care.

SECRETARY CALIFANO: But somebody has to pay.

MS. KLAFTER: You wouldn't have fees. It would be government financed, paid for by a truly progressive special tax and out of general revenues.

[redacted]

"I would strongly recommend phasing in national health insurance with preventive services to children and their families."

PROF. NEIL BRACHT *of the University of Washington's School of Social Work, representing the National Association of Social Workers:* I would say on phasing in national health insurance, we need to emphasize prevention. I represent some 46,000 social workers who work in the health care field. We have intimately seen the breakup of families

from disease and disability. The number of disabled people whose marriages end in divorce is nearly twice that of non-disabled. We are especially supportive of your goal for prevention and comprehensive health care.

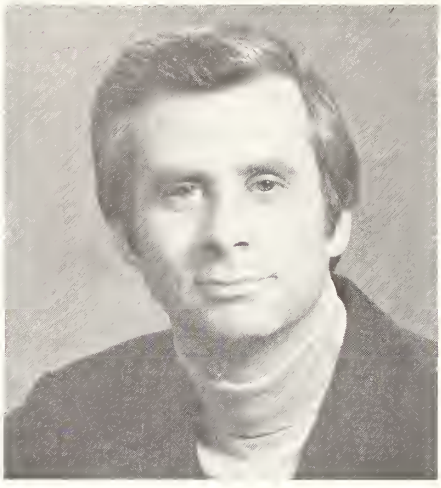
You mentioned earlier that you wanted to know whether incentives should be built in for helping people change their lifestyle or improve living habits. I don't know exactly how to build those incentives in, but there ought to be some incentive both for providers and consumers.

SECRETARY CALIFANO: What about covering paramedicals or social workers? Are there people in your organization who you think would fit within a national health plan coverage, and have you thought about any way of identifying them, classifying them?

PROFESSOR BRACHT: Social work and allied disciplines are covered under a number of programs. Our prepared testimony outlines how those people can be identified and some of the services they provide. On the question of certification, 70 percent of our membership have a master's degree.

It is important to point out that from one-third to one-sixth of all chronic disease in this country starts in childhood. I would strongly recommend phasing in with preventive services to children and their families.

"I would like to see you delegate a group to do zero-base accounting of the institutions. Don't accept the current amount and say we will talk about how much you should increase it—let's see what the bucks are going for right now."



DR. NEIL SOLOMON, *secretary of Health and Mental Hygiene, State of Maryland:* You have been a proponent of accessibility to health care as a basic right of the individual. The question then is, do you have the manpower to pull it off now? There is no question about it. You do not. You will need 30 to 75 percent more manpower than you have now.

SECRETARY CALIFANO: Person power?

DR. SOLOMON: Person power. The worst thing we could do would be to laünch into a program and give great expectations to people, and then not be able to deliver, while at the same time increasing costs of health care.

SECRETARY CALIFANO: What kind of person power—doctors or nurses?

DR. SOLOMON: I am arguing a total comprehensive approach. Let's find out what kind of resources, the distribution of them and how to even them out. Let's talk about what type of paramedical people we need.

SECRETARY CALIFANO: The focus would be on paramedical?

DR. SOLOMON: Probably, because I think we can get more bang for our bucks that way. Having them on the team, with perhaps a doctor heading it up—having as many paramedical people as possible in various areas.

SECRETARY CALIFANO: As a doctor, you believe there is a great resource there to be tapped?

DR. SOLOMON: No question about it. The second area I would like to address is the exact role of the Feds, the States and the private sector? The Feds—broad-stroke policy and performance standards; the State—administration and regulation; the private sector—provision of services, with built-in accountability and built-in cost containment.

SECRETARY CALIFANO: How do you build cost containment into the system?

DR. SOLOMON: I think you can do it in several ways. We in the State of Maryland have a damned good record.

SECRETARY CALIFANO: You have a hospital rate commission that has been very effective.

DR. SOLOMON: We have a cost commission which has been effective, we have a comprehensive health plan that has been effective and we have PSROs that have been effective. I think you build in cost containment in the following way:

You first have to get control of where your major dollars are going and where they can be decreased without compromising health care. Historically we have been overdependent on the institutions which cost the most and are the least cost-effective. We ought to transfer those bucks and the patients to community-based programs in the private sector. I think we can save our bucks there.

I would like to see you delegate a group to go in and do zero-base accounting of the institutions. Don't accept the current amount and say we will talk about how much you should increase. Let's see what the bucks are going for right now.

I would venture to say once you did that in a comprehensive way—the

way in which someone would come in and audit your income tax or my income tax item-by-item—we would be able to save some real funds.

SECRETARY CALIFANO: So you would phase by the population, not by the type of service?

DR. SOLOMON: I did not say that. In this alternative, I would give comprehensive health care to the poor, to the kids, to the old people and then phase in the other groups as dollars became available.

As alternative No.2, I would have a certain benefit of services for all people in this country, and then increase the services as the dollars came in.

How much is it going to cost? Who is going to pay for it? Where is the money going to come from? I can tell you that I have not seen any hard data to tell us accurately how much it is going to cost. I think that is the first thing you need to know. But regardless, I think you have to know one thing. There is no way that the States can pick up an increase in health care costs. To think that would be deluding yourself. You, the Federal Government, are going to have to pick up the extra bucks.

SECRETARY CALIFANO: Spoken like a state public health administrator.

[redacted]

"In our opinion, General Motors employees and their families and other Americans in similiar positions would be better served by a strong coordinated effort to contain the escalating health care insurance costs than by a broad program of national health insurance."

VICTOR M. ZINK, *director of employee benefits and services, General Motors Corporation:* Good morning, Mr. Secretary.

SECRETARY CALIFANO: Is it true or is it a myth that there is more medical care in a General Motors car than steel?

MR. ZINK: It is a myth.

SECRETARY CALIFANO: Do you pay all the insurance expenses for your employees—100 percent?

MR. ZINK: Essentially we do. Factually, this is not completely true. We pay the full cost of all basic coverages and about two-thirds of the cost for major medical coverages which apply to salaried employees and retirees.

SECRETARY CALIFANO: Does that have any impact on utilization?

MR. ZINK: We think it does, and we are in the process of doing studies on that. The projected expenditures for our health care coverages for the next 12 months for each active General Motors' employee in the United States, is about $2,300. Of course, we also cover their families, people laid up and on leave, and retirees.

SECRETARY CALIFANO: So I suppose the United Auto Workers would say, if there were national health insurance, those employees would have another $2,300 in pay?

MR. ZINK: Not really. In our opinion, General Motors employees and their families and other Americans in similar positions would be better served by a strong coordinated effort to contain the escalating health care insurance costs than by a broad program of national health insurance.

SECRETARY CALIFANO: How would you contain the costs?

MR. ZINK: I was going to get into some areas. Talking about coordinated efforts, we have government, industry and labor working with the Michigan hospital association trying to eliminate some of the excess beds in the State.

[redacted]

"We believe that, rather than blanketing the whole country, coverage should be targeted to those who need it—the unemployed, people between jobs and those marginally covered."

WILLARD G. HOPKINS *of Booz-Allen-Hamilton, representing the National Association of Manufacturers:* We believe that implementing national health insurance is premature at this time. Without demonstrating

workable controls to slow rising costs and assure quality services, there is reason to believe that current proposals to expand coverage are likely to only add to the problem.

SECRETARY CALIFANO: How would you control costs?

MR. HOPKINS: I like to divide cost controls into three categories. First, control capital expenditures to assure that there is no unnecessary duplication of service and that there is adequate distribution and efficient use of medical technology.

SECRETARY CALIFANO: Stop this keeping up with the Joneses?

MR. HOPKINS Yes. Second, provide quality controls of the PSRO type to assure the quality of different levels of care, both inpatient and outpatient, and the reduction of unnecessary hospital services. Third, use reimbursement programs to bring about greater system efficiency and provide incentives to encourage more effective distribution and cost reductions.

So we are talking about three types of economic controls: (1) control of resources that are available to furnish medical services; (2) controls to assure appropriate utilization of resources; and (3) reimbursement incentives to promote more effective and efficient operation of the medical care system.

Finally, the association is very supportive of a reform of the Medicaid and Medicare programs to reduce fraud and abuse and to demonstrate the Government's ability to coordinate administration of the programs it now has.

We would like to see a program designed to encourage a multiplicity of delivery systems and develop some new ones, such as HMOs.

Rather than blanketing the whole country, national health insurance coverage should be targeted to those who need it—the people in the cracks—the unemployed, people between jobs and those marginally covered. The association would also endorse minimum benefits for everyone.

SECRETARY CALIFANO: And the minimum benefits that all employers would be required to give their employees.

MR. HOPKINS: Right. Continue coverage of the working population through the employer/employee-financed programs where this is shared, with the employers continuing to select their own insurance carriers. Finally, the Administration should rely upon the private sector for insurance programs and not look toward combining all programs under a Federal umbrella at this time.

Employers favor joint employer-employee financing, rather than payroll deductions and premiums collected by the Federal Government.

[redacted]

"Reliance on Federal taxes to cover all groups will reduce the interest of local communities in developing cost-effective health systems and will replace that interest with a race to maximize each community's share of the Federal dollar."

J. ALEXANDER McMAHON, *president of the American Hospital Association:* We are very pleased in presenting our views on what we like to call "universal health insurance" to put the emphasis on universal coverage rather than on a nationally-financed system. The AHA has for a number of years endorsed Congressman Ullman's National Health Services Reorganization and Financing Act as best addressing the problems and achieving the goals we seek.

The first major problem that we face is the rising cost of health care, a topic you are familiar with, because of inflation, improved technology and the demand for care stimulated by governmental and private health insurance programs.

The second problem is uneven access to health care services, because of shortages and maldistribution in both facilities and manpower. And the third is the regulatory system that is complex, duplicative and conflicting, consisting of a host of Federal Government, state government and private regulations, standards, guidelines, surveys and audits.

We have five major goals. First, the removal of the financial barriers to health care by providing universal and continuous health insurance coverage for all Americans.

Second, the use of multiple sources of financing, including mandated health insurance for employed people, payroll-tax financing for the elderly through Medicare, and a combination of Federal and state general tax revenues to buy insurance for the poor, the near-poor and the needy unemployed. Reliance on Federal taxes to cover all groups will reduce the interest of local communities in developing cost-effective health systems and will replace that interest with a race to maximize the community's share of the Federal dollars.

The third goal is the phase-in of a comprehensive package of benefits, including both preventive care and early detection, and catastrophic coverage. The demand resulting from the present system is a major contributor to cost escalation.

SECRETARY CALIFANO: Are you saying phase in catastrophic coverage first?

MR. McMAHON: No, I would start with an improvement of the present Medicaid program, making that a more uniform and equitable system across the country for the poor, the near-poor and the needy unemployed.

Then I would put the emphasis on preventive care and early detection, because of their lower costs. Catastrophic coverage, of course, is the greatest political concern. Two out of three employed people now have catastrophic coverage through major medical, and it would be a fairly simple matter, in time, to mandate something in the catastrophic coverage area. But I would do the lower-cost things first.

The fourth goal is incentive, both to providers and consumers, to develop coordinated health delivery systems looking for the lower-cost comprehensive systems. The fifth goal is the creation of an efficient and coordinated regulatory system combining cost containment, planning and utilization review.

SECRETARY CALIFANO: Like the one the President proposed?

MR. McMAHON: No. We urge cost containment, planning and utilization review operating at the state level under Federal guidelines. We think that would be the best approach to a coordinated system.

[redacted]

"Benefits and services must be truly comprehensive, covering all personal health care services, including specialty programs."

TERRANCE PITTS, *supervisor of Milwaukee County, Wisconsin, representing the National Association of Counties:* Counties pay 10 percent of the annual 17 billion (and growing) Medicaid bill. In addition, counties own more than 10 percent of this country's hospitals. Over 45 percent of the public hospitals are owned by counties.

We believe the demonstration programs run by Contra Costa County, California, and Multnumah County, Oregon, are the most innovative approaches that exist for providing care to medically indigent people. Both are applying the concepts of prepayment, group practice and comprehensive delivery systems to ensure several choices of alternative care with effective cost and quality controls. We urge you, Mr. Secretary, to give these projects your attention as ways to provide adequate care while getting a handle on rising health costs.

SECRETARY CALIFANO: I intend to send someone to both of those projects.

MR. PITTS: Mr. Secretary, the association has urged repeatedly over the last few years immediate enactment of a comprehensive national health financing program.

SECRETARY CALIFANO: How would you set the roles of the Federal Government, the states and local governments?

MR. PITTS: We would first like to see the federalization of Medicaid, and we think that would be the first step on an incremental basis.

SECRETARY CALIFANO: You mean not only picking up the costs but administering the entire program?

MR. PITTS: Yes, sir.

SECRETARY CALIFANO: In a national health insurance plan that covered all American citizens, are you in favor of completely operating that as a Federal program?

MR. PITTS: We would like to have some local control, but we believe, because of the impact of the costs in terms of its effect on local governments and the property taxpayer, and the increase in costs that counties are having to pay from the property tax base, that it would be in the best interests of this country if Medicaid were federalized.

SECRETARY CALIFANO: The Federal Government would pay the tab and it would be administered locally?

MR. PITTS: As long as there were financing mechanisms to handle the administration of it on the local level.

SECRETARY CALIFANO: Spoken like a representative of the National Association of Counties.

MR. PITTS: The costs of enrollment in programs emphasizing prevention, early access and comprehensive benefits are out of reach for many of those who could benefit most from health maintenance services. With an insurance system which emphasizes sickness care and hospitalization payments, we perpetuate barriers to staying healthy and preclude less costly alternatives for care.

SECRETARY CALIFANO: If the plan were phased in, which diseases or problems would you address first?

MR. PITTS: The problems which are not covered by most insurance packages, such as alcoholism, drug abuse, mental health—we think these items should be included in the program. We would like these gaps covered, but we haven't put any true emphasis on the priorities per se.

We endorse the principle of a single universal comprehensive health insurance system.

Benefits and services must be truly comprehensive, covering all personal health care services, including specialty programs—preventive medicine, rehabilitation services, mental health care and similar specialty care programs which are the traditional responsibilities of county government. There must be no arbitrary limit on the quantity of services available to a patient. Counties must have an integral role in the development and administration of a national health insurance program.

"The insurance companies are mostly concerned about their profits, and Blue Cross and Blue Shield plans have been dominated by doctors and hospitals."

JAMES TURNER, *representing the United Auto Workers:* Having to negotiate health insurance coverage has become an increasingly serious obstacle in collective bargaining.

SECRETARY CALIFANO: You would rather have the $2,300 in direct wages that General Motors is paying out in health insurance?

MR. TURNER: The cost of our negotiated health care programs with the big three auto companies is now 95 cents to $1 per hour and each penny of this is worth about $8 million at General Motors alone. This is money which is being diverted from wages and other benefits to pay hospitals and doctors. Most of the increases our union has been able to negotiate have gone to pay increases in health care premiums for benefits for which we already bargained.

SECRETARY CALIFANO: So you are in effect negotiating to pay for the health care inflation.

MR. TURNER: We have to run to keep up. All the increases are going to cover inflation. Even though our union negotiates hundreds of millions of dollars of health insurance benefits, we have found the private insurance industry to be very unresponsive to consumer needs. The insurance companies are mostly concerned about their profits, and Blue Cross and Blue Shield plans have been dominated by doctors and hospitals.

SECRETARY CALIFANO: If the national health insurance were phased in would your first target be the poor and the unemployed?

MR. TURNER: I think that would be one of the primary first targets and the other would be preventive medicine.

Medicare benefits were limited from the beginning, and they have been falling farther and farther behind due to inflation of health care costs. Our union believes that a sound national health plan should embody the following principles enunciated by President Carter in his election campaign last year:

Coverage must be universal and mandatory. Every citizen must be entitled to the same level of comprehensive benefits. Barriers to early and preventive care must be reduced to lower the need for hospitalization■

Seeing is believing.

He will never find the answer if he can't see the problem. If your child needs glasses, the Medicaid Program can provide them. Just as we provide immunizations against polio, whooping cough, and measles . . . treat anemia, TB, and sickle cell disease. To find out if your family is elegible, contact your local Social Service or Welfare Office today. Medicaid. Worth looking into.

For a free supply of these posters, write: Editor, the *Forum*.

The Stacks of Federal Forms Come Tumbling Down.

by Teri Smith

The mountainous stacks of Government forms, which have for years furnished comedians with a constant flow of joke material—fill out six forms, mail three, file two and destroy one—are at last being chopped down to size.

As part of a Government-wide effort to reduce unnecessary forms, the Health Care Financing Administration has cut its stack by 35 percent. It took nine months to purge 44 forms from HCFA's inventory of 126 forms used to collect information from the public. Employees continue to work toward the HEW goal of eliminating 50 percent of the time required to complete the forms that were in existence on June 30, 1976. HEW's deadline for the planned reduction of forms is June 30, 1978.

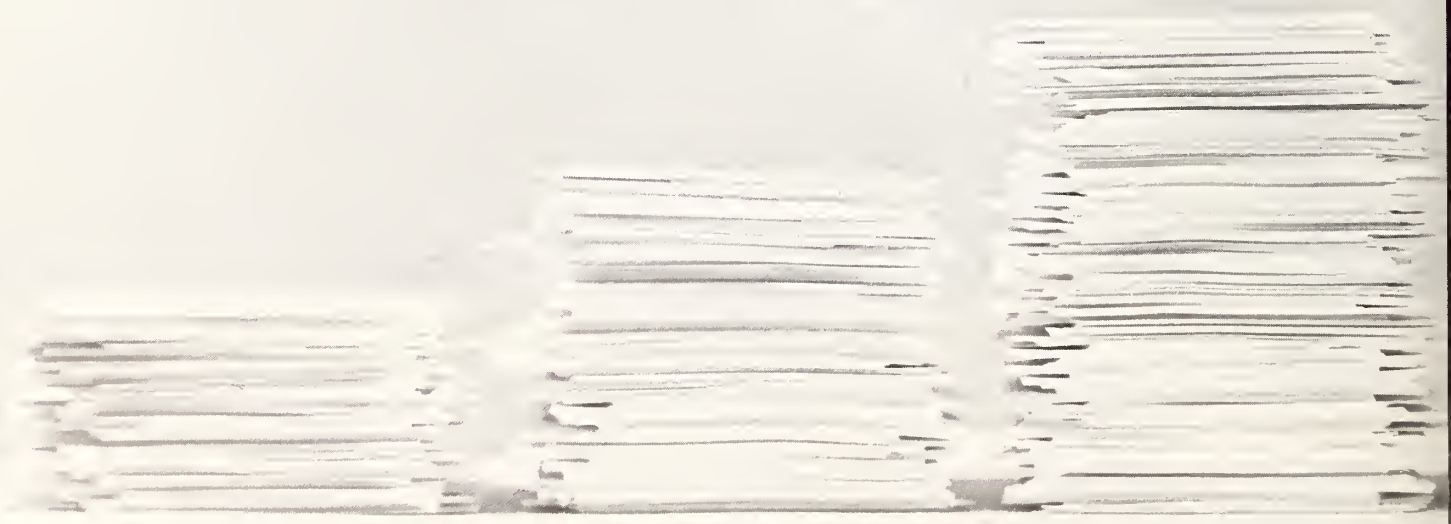
Of course there is always the danger that, in eliminating forms, some zealot will combine two of them, but keep all the questions and even add new ones. To forestall this, HCFA is also aiming to reduce by 50 percent the number of questions on each form used by the public.

The cutback is a result of a paperwork reduction program initiated under the Ford Administration and intensified by President Carter. Focus of this effort is on the so-called public-use forms—those used to collect information from 10 or more persons.

While this will lighten the reporting burden of the general public, the number of forms that Government employees and agencies must fill out will not be affected, at least for a while.

Thus far, the elimination of HCFA forms is estimated to have saved nearly 1.5 million hours of paperwork—down from 15,017,717 hours to 13,538,742.

But the savings do not stop there. Time and money are also being saved because Government employees do not have to print, distribute, collect, review, process, computerize and analyze the forms. The savings in avoiding these steps has



not even been guessed at.

An example of paperwork reduction is the consolidation of HCFA's Medicare cost reporting forms used by hospitals and skilled nursing facilities. The 15 now being used will soon dwindle to two: one for facilities with 100 or more beds, the other for those with less than 100 beds. This is expected to reduce the time to complete the forms from 751,900 hours to 300,000.

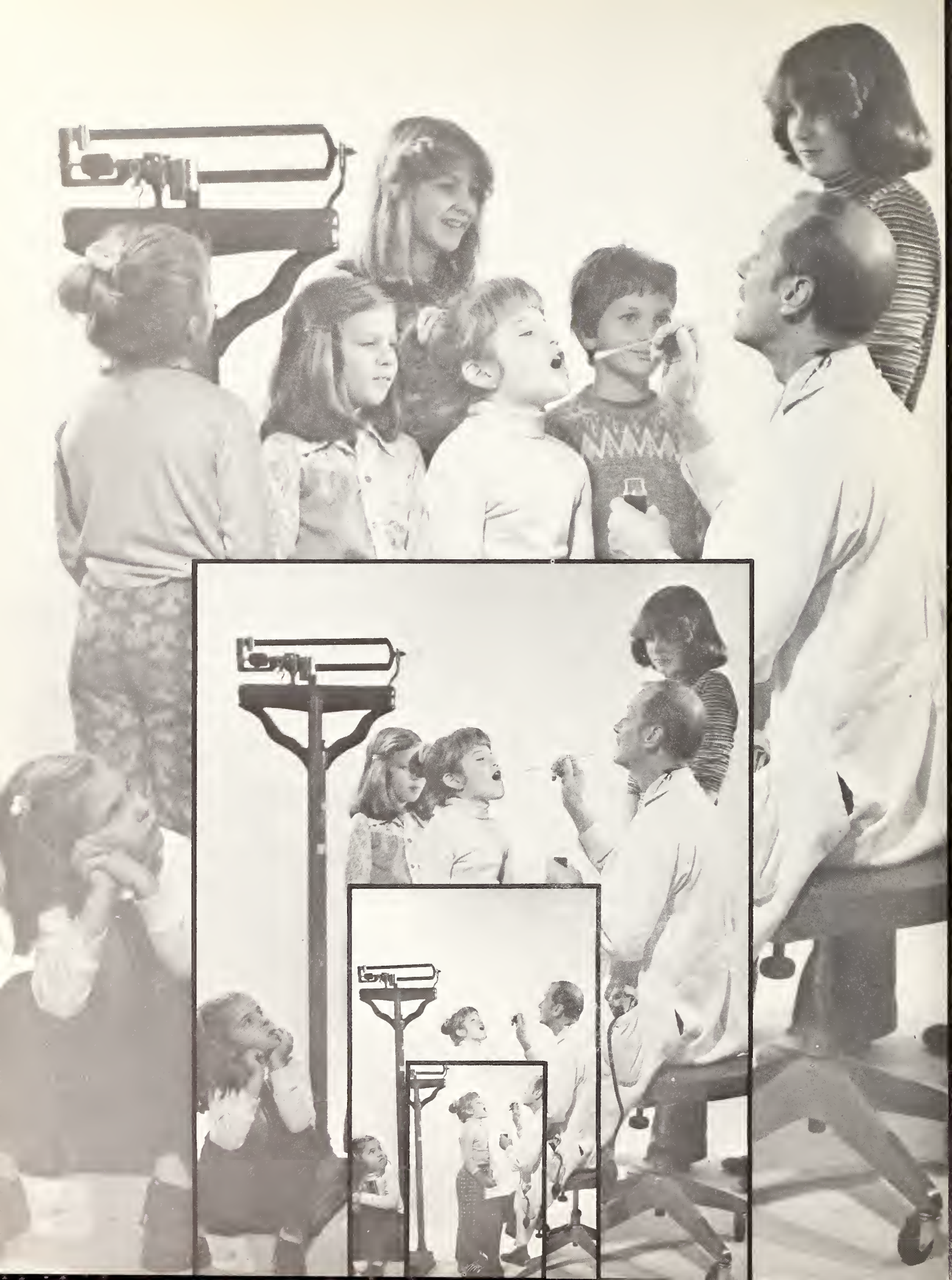
Underlying the reduction is a dual premise: (1) unnecessary information is being collected; and (2) there is duplication of effort, that is, different agencies or components of the same agency are requiring the same information from the same people. In spelling out the philosophy for the collection of information, an HEW memo advocated "risk taking in reverse." Rather than following the established pattern of collecting data "simply because we may need it, and it is best to play it safe," data should be gathered only when absolutely necessary.

To avoid duplication of effort, some forms are being reviewed to see if they can be combined to serve several requirements—sometimes of different agencies. For example, in the planned revision of the certification process for those providing services to Medicare, Medicaid, and CHAMPUS patients, one survey form will suffice for participation in all. This form will be the same for all the providers and a few special types of facilities, such as tuberculosis and psychiatric hospitals, will have to supply additional information on supplementary forms.

Recently, HCFA has been able to eliminate a whole category of forms in one stroke—the pre-survey forms. They had been used to gather information about organizations to help surveyors plan for the most efficient method of obtaining more detailed information during the certification survey process. It was decided that the advance surveys were unnecessary because the questions asked could be substantially reduced and included on other forms.

Not every component of every HEW agency will be able to reduce its forms by 50 percent and shorten the remaining ones, because Congress requires certain information to be collected. However, Congress is studying recommendations that will lessen reporting requirements, so those stacks of forms should continue to fall. ■

1970 **1977** **1978**



Study Finds EPSDT Program Growing in Effectiveness.

by John C. Miller

The program for assessing the health of children of low-income families and treating the problems found has had less than its share of good news since getting off to a slow start in 1969. Only in the last two years did activity markedly increase and nearly as many children were examined as in the previous five years.

But examination for health problems was one thing and their treatment quite another. State Medicaid agencies were unable to determine whether or not the problems found in examination were treated.

The lack of data on treatment was highlighted by a 1975 study, *Shortchanging Children*. This study, commissioned by the House Subcommittee on Oversight and Investigations, showed that less than one-sixth of the 12 million eligible children were being examined, and only 60.4 percent of the children needing treatment received it. It then concluded that the remaining children not examined were "at risk."

However, subsequent analyses by the Medicaid Bureau have shown that only about half of the children eligible for the program could be expected to be examined, considering the degree of program acceptance and the intervals states set between examinations. In addition, half of the children who were examined were found to be perfectly healthy, and the remaining half averaged about 1.5 problems per child. However, the relatively low treatment rate of 60 percent remained unchallenged until a recently-issued study* commissioned by the Medicaid Bureau revealed more encouraging figures.

It shows that 78 percent of the children who were examined in eight states and Puerto Rico received initial treatment for at least one problem, with 72 percent receiving treatment for all their problems. The report concludes: "To be considered a mature and fully effective national program, between 80 and 90 percent of children who are examined and found to need treatment should receive it. Medicaid's Early and Periodic Screening, Diagnosis and Treatment program is now rapidly approaching this range."

The study, performed by an organization with long experience with EPSDT, the Health Services Research Institute of The University of Texas, suggested why previous reports indicated that a significantly lower percentage of children were being treated.

One reason: the new study gathered data at the local level by actually tracking children from examination to treatment. The routine reports received by the Medicaid Bureau came from state Medicaid offices, and some data on treatment may have been lost in the reporting process. Indeed, the study often found a greater number of children were treated than reports from state Medicaid offices indicated. The House Subcommittee on Oversight and Investigations also gathered its information at the state level.

Another reason for variation was that the new study covered a more recent period than previous reports. As it matured, the program reached a higher level of effectiveness.

Children not treated

Of the children with problems who were not treated, slightly more than one-third either refused treatment, were no longer eligible because of a change in their family income, no longer appeared to have a problem or failed two or more times to keep appointments for treatment. Another six percent were on the waiting list to receive treatment when the study was made.

But what of the rest of the children who were not treated? Many times, the information necessary to determine if these children received treatment was lacking, even though there were five separate records that should have showed whether or not a child was treated. In these cases, either the name of the professional to whom they were referred was not listed or the address or telephone number of the childrens' parents was missing.

Typically, records showed: "No record of child," "No record of Medicaid number," or "Files incomplete."

A major segment (27 percent) of children who were not treated missed appointments or refused treatment. Since it is "often times necessary to convince a parent or guardian that a seemingly well child needs to go to the doctor, the probability of achieving a 100 percent participation in the program . . . . is exceedingly remote, if not outside the realm of possibility," the study points out.

Of the four categories of problems identified, significantly fewer children were treated for dental problems. The study found this was due to low rates of reimbursement for dentists. Indeed, it points out that the lack of dentists accepting referrals was a frequent concern of local EPSDT program workers.

Another reason for a low dental-treatment rate was probably that parents did not recognize the value of preventive medicine. Of the children who refused treatment, nearly half refused dental treatment.

In an effort to improve the rate of treatment, a requirement for a better information system was written into penalty regulations and reporting requirements published in September. The requirement would become effective January 1979.

Case monitoring a factor

Another factor that appeared to affect the states' rate of performance was case monitoring—the system for notification of eligibility and following a child from examination through treatment until eligibility ceases. The

*Reviews of Shows for Treatment EPSDT—a Nine-State Study.

rate of treatment was significantly higher in those states which recognized case monitoring as a specific function of the EPSDT program and assigned that task to a single state agency.

But where the responsibility for case monitoring was assigned to the provider of treatment or to an agency not responsible for the entire program, or where case monitoring was not clearly identified as a separate and highly desirable task within the program, the state's performance tended to be low. This was the case with each of four states that had the lowest treatment performances.

Money spent for case monitoring varied considerably among states. Generally, the more allocated to this function, the better the overall performance. Expenditures ranged from just pennies per child examined to an estimated $10 to $15 per child.

The Medicaid Bureau is developing a model system for tracking children from the time they are first informed of their eligibility for the program, through examination, and until the problem is resolved.

State performance varies

The 78 percent treatment factor was an average performance for the eight states—California, Georgia, Iowa, Michigan, Ohio, Pennsylvania, Tennessee and Texas— and Puerto Rico. However, the range of performance was extremely wide—from 87 percent in Pennsylvania to 55 percent in Tennessee. Interestingly, Pennsylvania had the lowest number of undocumentable cases and Tennessee had the most.

These ratings do not, however, indicate the effectiveness of each state's

EPSDT Treatment Rate by State

	Number of Children With Problems	Children Treated at Least Once		Adjusted* Number of Children With Problems	Adjusted* Percent Treated
		Number	Percent		
Texas	368	263	71.5%	342	76.9%
Pennsylvania	579	466	80.5	528	88.3
Georgia	313	234	74.8	311	75.3
Tennessee	407	247	60.7	384	64.3
Michigan	439	351	80	421	83.4
Puerto Rico	280	179	63.9	271	66.1
Iowa	287	216	75.3	287	75.3
California	371	267	71.9	331	80.7
Ohio	378	299	79.1	365	81.9
Total	3,422	2,522	73.7%	3,240	77.8%

*After deletion of children who refused treatment and those who no longer had a problem.

Note: These data, in themselves, do not indicate the degree of effectiveness of state programs since the costs of the programs are not included in this study.

program, because the costs of the programs were not considered. A number of factors, aside from sufficient resources to do the job, were cited as possibly influencing a state's performance. These include:

- Whether the EPSDT program was operated by a state agency or contracted to a private organization.
- Socio-economic variations among the states.
- Environmental conditions, including factors such as the amount of fluorides in drinking water.
- Cultural norms.

Generally, a state EPSDT program was organized as follows: (1) the state department of public welfare was responsible for the overall program and located children who needed examinations; (2) the State health department performed the examinations; (3) referrals for treatment were made to private clinics; (4) case monitoring was performed by the agency responsible for locating the children for examination.

It should be noted, however, that this structure varied considerably from state to state and in some cases within the same state.

Improving the system

The study focused on poor documentation, which made it difficult or impossible for some states to determine whether health problems found in the screening were actually treated. The new proposed reporting requirements and the Medicaid Bureau's model program for tracking children through the system represent efforts to address this deficiency.

However, the variety of other shortcomings found suggests that each state program must be evaluated within the frame of its own organizational structure, eligibility requirements, and frequency and extent of examination of children. To improve the EPSDT program throughout the country, a number of steps are being taken. These include:

Program Improvement Plan. The EPSDT program of each state is examined to pinpoint problems that are keeping the states from filling program objectives. A plan is then developed to help each state upgrade its program.

Technical Assistance. The Office of Child Health offers technical assistance to help a state implement its Program Improvement Plan. When the central or regional office is unable to help solve a problem, an independent contractor is often available to provide technical assistance.

Case Monitoring. A model information system designed to reenforce case management is now being completed and will be available to states in early 1978.

Interagency Agreements. Because of the many child care programs operated by various agencies, it is important to insure that unnecessary overlapping does not occur. Interagency agreements are developed in such areas for identifying the population to be served, the objectives of the program and the methods that will be used to accomplish the objectives.

Provider Participation. OCH encourages the states to publicize the EPSDT program to providers and to set their reimbursements for providers high enough to attract a sufficient number of them. To ease the paperwork burden for physicians, the AMA is working with the agency to develop a standard billing form that can be used by physicians for all health care programs.

Methodology of the Study

The study focused on a random sample of 3,240 children who were examined between January 1 and April 30, 1976, and found to have problems. Four-hundred children were scheduled to be chosen from each of eight states and Puerto Rico, each of which had a high number of children examined during the preceding quarter. But the random quality of the study suffered when three states declined to participate and other states were substituted.

The eight states and Puerto Rico had about 44 percent of all children who were eligible for EPSDT and, coincidentally, they examined 44 percent of all children in the program during the third quarter of 1976.

Each state was asked to submit a list of five urban sites and five rural counties, each with a minimum of 400 children. Three urban and two rural sites in each state were randomly selected. Each child was assigned a number, and a sample of 80 children was drawn from each site.

Because an extremely high incidence of dental problems was found, it was decided that, if necessary, the number of dental cases checked at each site could be limited. This would insure that there was a sufficient number of other problems to make the study statistically valid. The limitation was imposed in only one state. Cases of deficient immunization were deleted for the same reason.

Other factors limiting the random quality of the study were:

- A site had to have examined at least 400 children during the period designated or it was not considered. This requirement insured there would be adequate numbers of children with referrable problems.
- The decision to use three urban sites and two rural ones in each state to assure the proper urban-rural representation was arbitrary.
- The degree to which the examination uncovered problems and identified them varied.
- Of the sites considered, there was extensive variation in the maximum number of children examined.

The data was collected by questionnaires sent to the local EPSDT staffs. Whether or not a child was treated was determined by checking clinic, welfare and Medicaid payment records, or through a visit or telephone call to the provider or the patient's parent.

A member of the survey team visited each site to resolve questions and insure that survey questionnaires were as complete as possible. While at the site, team members also verified a random sample of 20 percent of the forms, finding an error rate of between three and five percent. ■

Computerized Kidney Registry Links Tra

by Teri Smith

A small nonprofit foundation is helping find kidneys for about 2,000 persons across the United States this year, well over half of those who will receive kidney transplants.

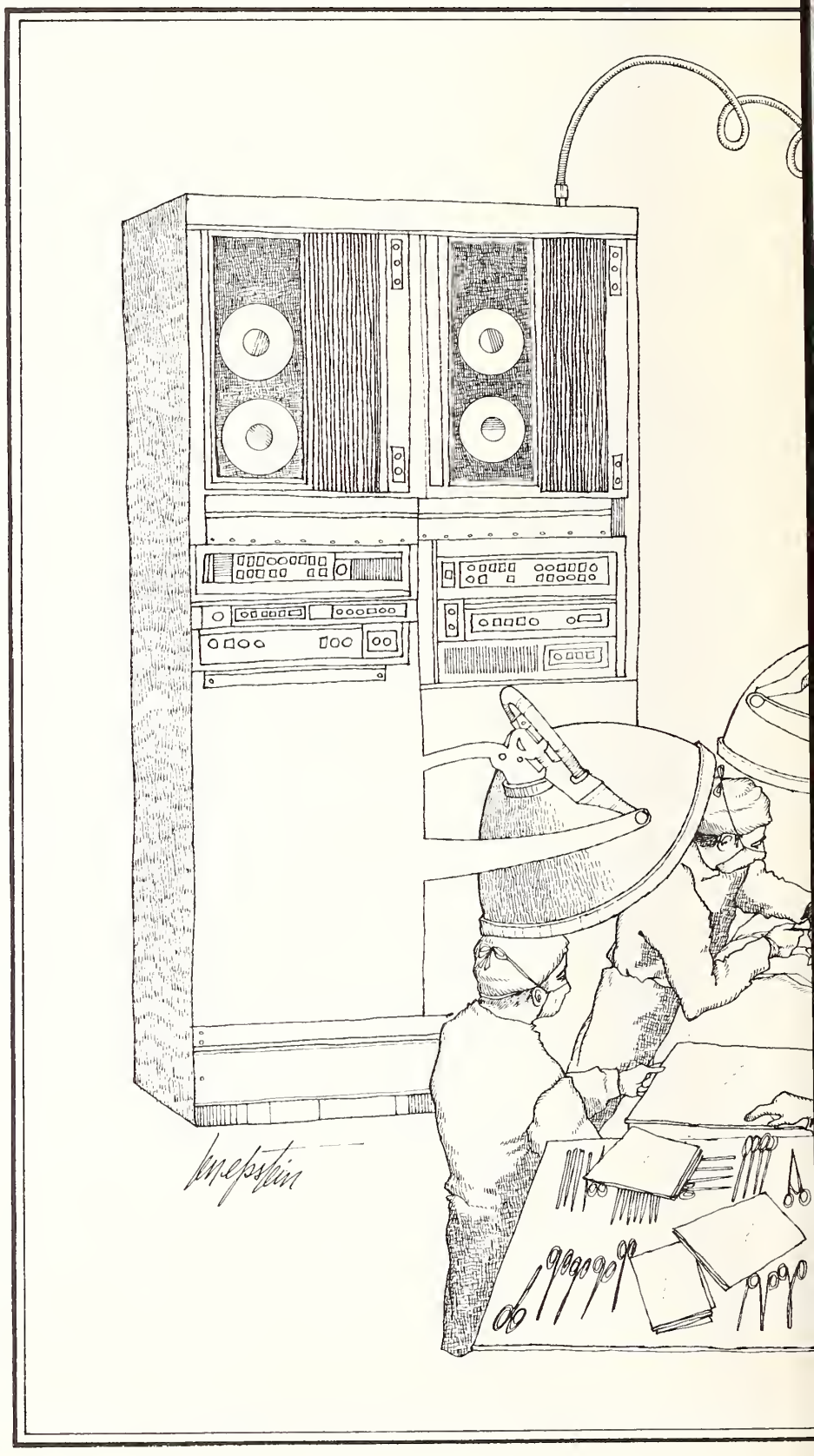
This surprisingly large volume of donor-recipient matches is possible because the South-Eastern Organ Procurement Foundation has linked 98 transplant centers around the country with a computer system.

The foundation began operation in 1969 with a four-year grant from the National Institutes of Health. Foundation membership then consisted of nine medical centers in four states. It now has 34 member centers, all certified to receive Medicare benefits, in 14 southeastern states.

In December 1976, the foundation opened its computer system to all certified centers in the United States. Centers began joining the system almost as fast as computer terminals could be installed—64 in one year. The system is known as the United Network for Organ Sharing.

"By widening the pool of donors and recipients, a higher percentage of organs can be matched and transplants accomplished at a relatively low cost to each participant," says Gene A. Pierce, executive director of the foundation.

The members of the foundation share the costs of operation, and all their billing is handled through the foundation. The costs to non-member centers that link up with the system are a charge for computer time, an $18 to $20-a-month telephone bill for tapping into the computer and rent or purchase of a computer terminal. Most buy the terminal, for between $1,800 and $2,500.



Matching kidney to recipient

After the surgeon removes a kidney scheduled for donation, it is typed according to tissue characteristics and the information fed to the computer for matching against the data bank of potential recipients. (The data bank is updated weekly.) The computer first looks for a local recipient who would

splant Centers.

be a good match for the organ. If this is not found, it searches the entire data bank and prints out a list of probable matches.

When the computer indicates a close match, a telephone call is made to confirm that the patient is still awaiting a kidney, before it is shipped out.

The organ can be preserved on ice for up to 24 hours. If it takes longer to find a recipient, the kidney is preserved on a portable machine. Airlines do not charge for kidneys shipped on ice, but one and a half fares are charged for kidneys shipped by machine, since a technician has to go along. At the destination, the kidney is transferred to a similar machine.

The final test for a match is performed when the kidney arrives. White cells from the donor are placed in blood serum from the potential recipient to determine if antibodies are present that would cause rejection. If the results are negative, the operation proceeds.

A refinement of this system has been made for patients who have been waiting so long for a kidney that they have become cytotoxic; that is, have built up at least five percent reactive antibodies. More than one third of the 3,000 potential recipients listed on the computer are patients of foundation members, and between 35 to 40 percent of them are cytotoxic. For these patients, the odds of finding a match are significantly reduced. To help improve the chances, samples of serum from such patients are exchanged monthly by member centers of the foundation. This permits the blood test to be performed at the center that provides the kidney.

Organs that become available through the computer network are from persons who die, mainly from accidents. Therefore, finding a recipient for a kidney is always a race against the clock. While some centers have performed successful transplants as long as 74 hours after removing the kidney from the donor, foundation members prefer to use kidneys within 51 hours. When a kidney that does not match any of those listed in the computer becomes available, the center contacts transplant facilities outside the United States. Thus far eight kidneys have been shipped overseas by foundation affiliates.

With the foundation's encouragement, several states have passed legislation making it possible to declare a person dead when brain waves cease and certain other criteria are met. The kidney may then be removed, if the next of kin consents to the operation or the person has filled out a donor card.

By the early 1970s, all states had passed a Uniform Anatomical Gift Act. As a result of this act, those who decide in advance to donate their organs carry a Uniform Donor Card. In many states, the donor card is incorporated in the driver's license.

Improving kidney transplants

Though every effort is made to find a recipient, about 30 percent of kidneys are lost, some because no match can be found and others due to medical problems—such as the ureter's being cut too short or previously undetected damage to the kidney itself.

Methods of lowering this loss and improving all aspects of transplants are under constant study by the foundation. Workshops have been held on such subjects as organ removal, tissue typing and preserving kidneys before transplant. As a result of the workshops, the foundation's criteria for typing tissue is now more rigid than the Government's standards. To insure that these criteria are met, the foundation has its own inspection teams.

"We find workshops to be extremely important in advancing the state of the art in transplantation" says Mr. Pierce. "It is in such workshops that significant strides have been made in the field. We are constantly looking for ways to increase successful transplantation.

"The growing network we now have for sharing kidneys is rapidly expanding and it could easily be extended to hearts and other organs." ■

Maximum prices set for ampicillin and penicillin.

Limits have been set on the amount that Medicare and Medicaid will pay for certain dosages of two widely prescribed drugs, ampicillin and penicillin VK. Maximum allowable costs (MACs) are also scheduled to be set for three more drugs by the end of 1977.

For ampicillin, reimbursement may not exceed 7.25 cents for each 250 mg capsule and 13.9 cents for a 500 mg capsule. The oral liquid form may be priced up to 1.45 cents for each 5 ml at the 125 mg/5 ml strength and 2.05 cents for each 5 ml at the 250 mg/5 ml strength.

Four forms of penicillin VK were assigned limits: 5.35 cents for a 250 mg tablet and 10.25 cents for a 500 mg tablet. In the oral liquid form of the penicillin, MACs were set at 1.2 cents per 5 ml at the 125 mg/5 ml strength and 1.6 cents per 5 ml for the 250 mg/5 ml strength.

Proposed price limits for capsule forms of tetracycline HCL, chlorodiazepoxide and propoxyphene HCL have been published and public hearings on them were held December 9. A final order is expected before the end of the year. It has been estimated that the chlorodiazepoxide MAC alone could save the taxpayer $2 million the first year it is in effect. Three more drug forms—meprobamate and phenylbutazone tablets and doxepen capsules—are currently candidates for MACs.

Suggestions for limits on drug prices originate with a board of Federal officials and are reviewed by the Food and Drug Administration. Proposed MACs are then considered by the non-governmental Pharmaceutical Reimbursement Advisory Committee and published for comment. In some cases, public hearings are held before the price is finalized.

Medicare carrier picked in fixed-price competition

For the first time, a Medicare carrier has been selected on the basis of a fixed price.

Blue Shield of Massachusetts was awarded the contract to process medical insurance claims for the State of Maine, beginning December 1. Previous contracts have been awarded on a cost basis. This departure from policy is possible under a section of the Social Security Amendments which allows experimentation. Criteria for selection included price, company experience and technical capability.

The 39-month contract is for $5.2 million, and compares favorably with contracts of other carriers operating in the traditional cost reimbursement manner.

Medicare insurance costs to rise in 1978.

December social security payments mailed to beneficiaries will be accompanied by a notice that hospital insurance deductible and coinsurance payments by the beneficiaries are being increased.

Those not receiving social security checks, but who qualify for Medicare hospital benefits will be notified of the cost increase by enclosures in the quarterly medical insurance premium notices in December, January and February.

For the first 60 days of hospital care during each benefit period, beginning January 1, 1978, patients will be responsible for $144, an increase of $20. From the 61st through the 90th day of hospitalization, the patient's share of the bill will increase by $5 to a total of $36 per day. For stays beyond 90 days, the patient's share for use of the 60 lifetime reserve days increases $10 to a total of $72 daily. For stays in a skilled nursing facility after the first 20 days, the patient's share will go up by $2.50 to a total of $18 daily.

"Runaway hospital costs" were cited by HEW Secretary Joseph A. Califano, Jr., as the reason for the increase. The Social Security Act requires that the deductible and coinsurance be adjusted annually for the difference between hospital costs for the previous year and those for the base year of 1966 when Medicare began.

Secretary Califano estimated that the six million Medicare patients entering hospitals next year will pay nearly $120 million more for their share of hospital costs. He also noted that payments under the hospital insurance program for hospital services provided to Medicare beneficiaries will increase by over $3 billion in that same period because of rapidly escalating hospital costs.

Dr. Smits designated to head HCFA bureau.

Dr. Helen Lida Smits has been designated director of health standards and quality for the Health Care Financing Administration, it was announced recently by HCFA Administrator Robert A. Derzon.

Dr. Smits, who is vice president for medical affairs of the Georgetown University Community Health Plan, Inc. in Washington, has extensive experience both as a medical clinician and a health administrator. Previously, she served as associate ad-

ministrator for patient care services at the University of Pennsylvania Hospital and assistant clinical professor of medicine and health care systems. A graduate of Swarthmore College and the Yale University School of Graduate Studies, she received her M.D. (cum laude) from the Yale University School of Medicine and is certified by the American Board of Internal Medicine.

Dr. Smits will oversee development and enforcement of standards and certification of hospitals, long-term-care institutions, ambulatory care and a full range of medical services, with responsibility for the Professional Standards Review Organizations program.

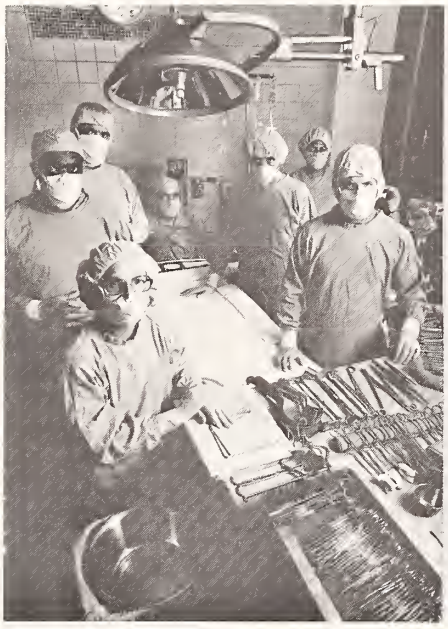
Rebate of drugs under Medi-Cal disapproved.

An attempt by the State of California to trim the costs of its Medicaid program (Medi-Cal) through competitive bidding by prescription drug suppliers has been voted down by the state legislature's budget committee. The committee disapproved a proposal that would have authorized a pilot program to test the plan in 11 counties.

Under the pilot program, the firm that won the bid on each of 75 most often prescribed drug products would have returned to the State a rebate on the total amount of the drug dispensed to Medi-Cal beneficiaries. The state would pay an incentive of perhaps 30 cents to the pharmacist to select the state-designated product when filling Medi-Cal prescriptions.

In opposing the proposed legislation, the spokesman for the Pharmaceutical Manufacturers' Association, Nicholas L. Ruggieri, expressed fear that many of its member firms would suffer substantial loss of Medi-Cal sales. However, a number of drug firms had indicated their willingness to bid for the Medi-Cal business.

Although the committee's decision was not binding on the California Department of Health, the state has delayed implementing the plan and hopes to modify it to meet the committee's objections to use of such rebates.



Blue Cross announces cost-saving program for '78.

New measures to hold down hospital costs and premiums for hospitalization insurance starting in 1978 were announced recently by the Blue Cross Association, which represents 69 Blue Cross plans and 85 million subscribers in the United States.

Unnecessary surgery, overhospitalization and uncalled-for laboratory and X-ray tests are among the culprits in a 15 per cent annual increase in hospital costs, according to Walter J. McNerney, president of the association.

To reduce inefficiencies and abuse, the plans will step up their examination of how hospital facilities are used. They will also check for fraudulent claims, but Blue Cross finds outright fraud to be rare, Mr. McNerney says.

Length of stay and kinds of services rendered for hospital patients will be scrutinized for medical necessity and appropriateness. The plans will also analyze each Blue Cross claim to be sure subscribers are receiving all the services for which the plan pays.

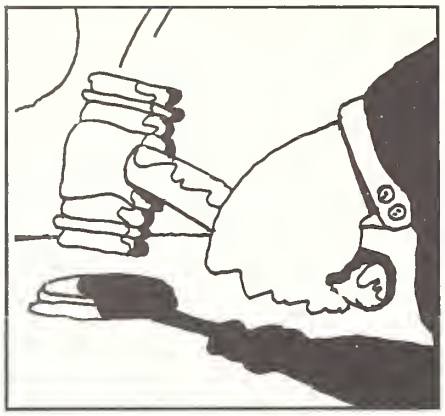
Eliminating duplicate payments to subscribers who are covered by more than one health policy is another requirement. Because this coordination of benefits is not legally possible in most States, Blue Cross will work to change laws that now allow duplicate coverage.

The cost-saving program also calls for an educational approach, using national and local television, newspaper and magazine advertising, posters, and mailings. The message: to tell individual subscribers, groups and providers how they can cooperate to lower medical care costs.

For example, a television ad campaign designed to coincide with the fall football telecasts will kick off the program early by reminding viewers of the importance of preventive medicine. The network ads will stress proper diet, sufficient exercise and sleep, avoiding smoking, and other ways of avoiding illness and injury.

All 69 plans voted to make the program mandatory for membership in the association. Actually, says Mr. McNerney, such efforts are not new—all the plans now use at least some of the cost-saving steps prescribed by the program, but the goal is to achieve a more uniform approach to cost control.

In addition to the steps that each Blue Cross plan must take under the mandatory program, certain optional activities are recommended to help contain costs. These include home care, second-opinion surgery, ambulatory same-day surgery and preadmission testing—all of which can decrease or eliminate hospital stays.



Fraud and abuse penalties increased by legislation.

Conviction of fraud by those persons providing services under Medicaid laws will now be classified as a felony instead of a misdemeanor under a new anti-fraud and abuse act signed by President Carter. Maximum penalties have been increased to a fine of $25,000, five years' imprisonment or both.

Among the provisions of the act, which takes effect immediately, are:

- Charging or accepting "contributions" to admit or keep a Medicaid patient in a facility is a felony.
- Physicians who accept Medicare assignment and repeatedly charge beneficiaries more than the federally-designated amount are guilty of a misdemeanor.
- Practitioners convicted of a criminal offense related to Medicare or Medicaid will be suspended from participation in both programs.
- To participate in Medicare, Medicaid, the Maternal and Child Health Program or Title XX programs, providers must disclose ownership of health care operations. The providers who must disclose the information include HMOs, suppliers, Medicare intermediaries and carriers, and Medicaid fiscal agents and suppliers. Program participation may be refused if owners, officers, directors, agents or management-level employees have been convicted of program fraud.
- A federal subpoena may be issued to facilitate review of any medical or social welfare program operated under the Social Security Act.
- Certain aspects of the Professional Standards Review Organization program are modified with respect to trial periods for conditional PSROs, conflict of interest provisions and PSRO reviews of Medicaid and Medicare programs.
- Purchase rather than rental of durable medical equipment for the Medicare program is required if more advantageous.
- Personal funds of Medicare and Medicaid patients must be properly accounted for.
- Physicians and suppliers are discouraged from selling their Medicare and Medicaid accounts receivable to bill collection agencies, and State Medicaid plans must pay 90 percent of routine claims within 30 days and 99 percent within 90 days.
- A uniform reporting system will be required that will allow a better comparison and review of provider performance.
- Sanctions against a state failing to meet Medicaid long-term care review requirements are modified to take into consideration the nature and degree of non-compliance.

Fraud and abuse taskforce uncovers widescale fraud.

Between 20 and 25 indictments for Medicare and Medicaid fraud will be sought by the U.S. attorney in Tampa.

Investigations show that between $4 and $5 million in Medicare funds have been syphoned off by Medicare providers and their confederates. The cases involve nursing homes, medical supply companies, podiatrists, a hospital, a pharmacy and a home-health agency.

Charges include kickbacks, falsifying cost reports and billing for services not rendered.

A fraud task force was led by Assistant U.S. Attorney Chris Hoyer, who has been devoting full time to investigating Medicare fraud in the area for more than a year. Mr. Hoyer asked for the assignment after the U.S. attorney's office in Tampa successfully prosecuted 11 Medicare fraud cases several years ago. Medicare disburses about $4 million weekly in the Tampa area, often called the Medicare Belt because so many retirees move there.

Preliminary investigations by the Atlanta Office of Program Integrity revealed widescale fradulent activities in Tampa in both Medicaid and Medicare. Mr. Hoyer was informed and two seasoned investigators from the program integrity staff joined in the investigation, furnishing background information on the program and identifying suspicious data, as well as helping with investigations and preparation of cases.

The FBI also participated in the task force. In the final segment of the investigation, 20 FBI agents with accounting backgrounds devoted 60 days to the project.

Indictments will not be sought until early next year, because a backlog of court cases will not permit trials to begin within 90 days after indictment.

Letters to the Editor

To the Editor:

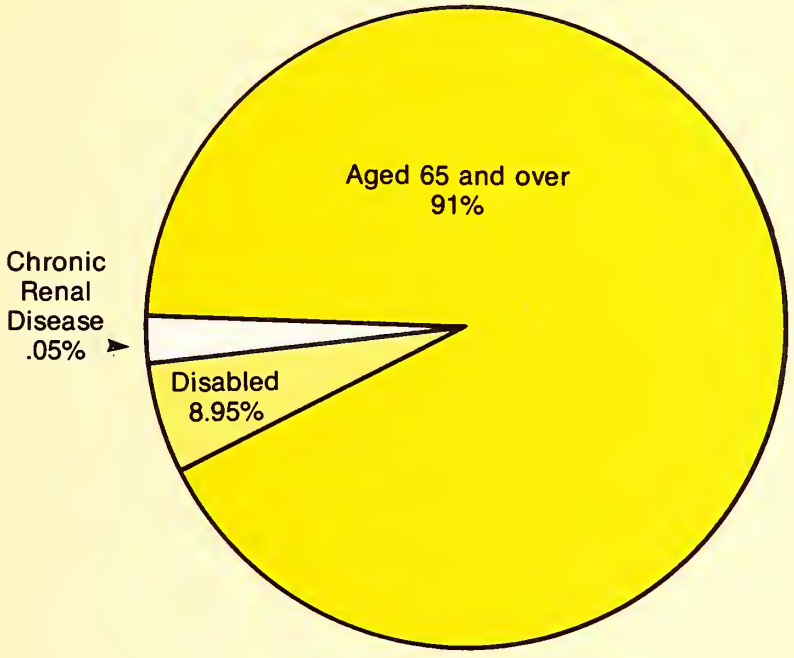
Of all the cost containment programs about which I have heard, the one you describe in the September/October 1977 issue of *Forum* is the most imaginative—and responsible.

Would you please have as much information as possible sent to me before we in Oregon get too far along with designing our own. We have a state legislature mandate to develop a rate review program during this coming year. The Yale model sounds an exciting possibility.

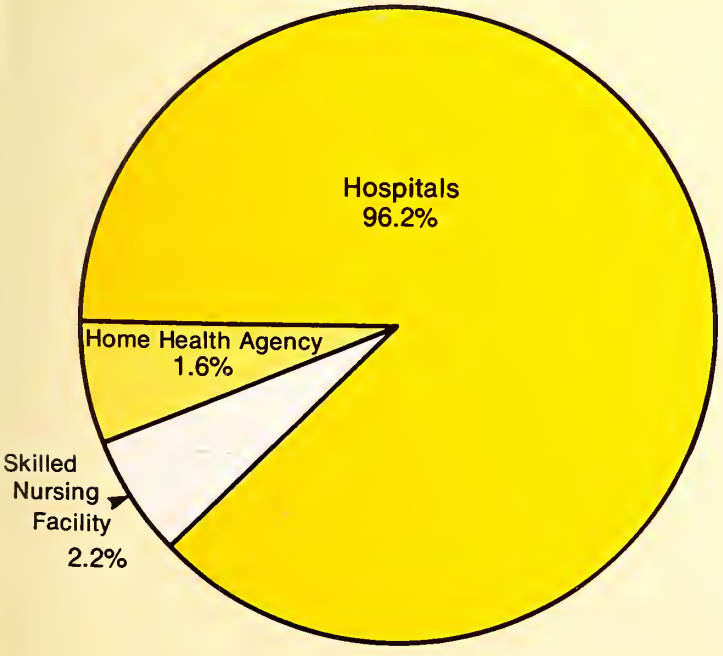
Christopher J. Stevenson, Manager,
Health Economics and Resource
Development Section,
State Health Planning
and Development Agency
Salem, Oregon

Medicare Enrollment and Payments for Fiscal Year 1977.

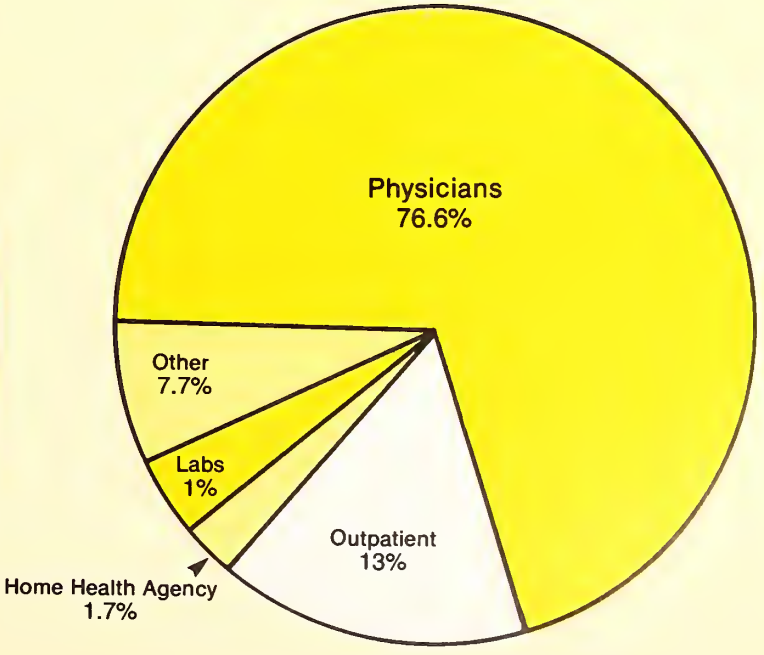
Type of Beneficiary



Type of Provider (Hospital Insurance payments)



Type of Service (Medical Insurance payments)



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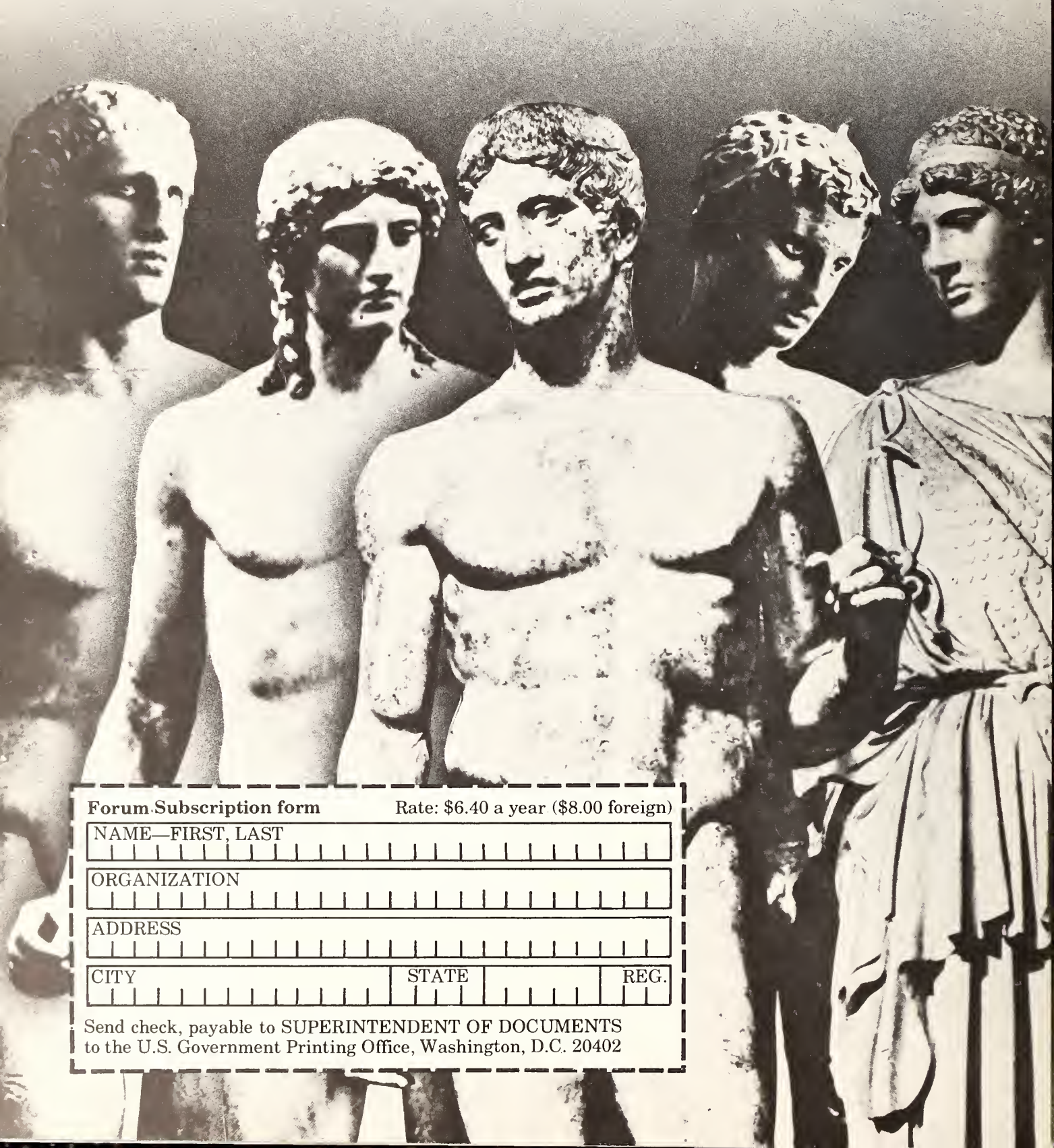

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